Public Laws: 102nd Congress / 1st & 2nd Sessions / Senate Reports / 1991 and 1992

Calendar No. 682

102D CONGRESS *2d Session*	SENATE	REPORT 102-409

WOMEN VETERANS HEALTH PROGRAMS ACT OF 1992

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

TO ACCOMPANY

S. 2973

SEPTEMBER 17 (legislative day, SEPTEMBER 8), 1992.—Ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE

59-010 WASHINGTON : 1992

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REPORT
102-409

WOMEN VETERANS HEALTH PROGRAMS ACT OF 1992

SEPTEMBER 17 (legislative day, SEPTEMBER 8), 1992.—Ordered to be printed

Mr. CRANSTON, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 2973]

The Committee on Veterans' Affairs, to which was referred the bill (S. 2973) to amend title 38, United States Code, to improve the care and services furnished to women veterans who have experienced sexual trauma, to study the needs of such veterans, to expand and improve other Department of Veterans Affairs programs that provide such care and services, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

COMMITTEE AMENDMENTS

The amendments are as follows:

Strike out all after the enacting clause as follows:

[SECTION 1. SHORT TITLE.

[This Act may be cited as the "Women Veterans Sexual Trauma Services Act of 1992".

[SEC. 2. CARE AND SERVICES FOR WOMEN VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

[(a) REQUIREMENT TO FURNISH CARE AND SERVICES.—Chapter 17 of title 38, United States Code, is amended by adding at the end of subchapter II the following new section:

[**"§ 1720D. Care and counseling of women veterans for sexual trauma**

["(a) A woman veteran who experienced sexual trauma that occurred during the period of the woman veteran's service on active duty and who is diagnosed by a Department health professional designated by the Chief Medical Director (following an examination of the veteran by such professional) to be in need of counseling or treatment for such sexual trauma shall be furnished care and services with respect

to such trauma pursuant to sections 1710(a)(1)(A) and 1712(a)(1)(A) of this title, even though such trauma has not been determined to be service-connected.

[“(b)(1) Notwithstanding any other provision of law, the Secretary may enter into contracts with appropriate non-Department facilities (as determined by the Secretary) in order to furnish women veterans with the care and services (including any diagnostic services) referred to in subsection (a).

[“(2) Not later than January 31, 1993, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the use made of the authority provided under paragraph (1) before the date of the report. The report shall describe the extent of the use of that authority and the types of care and services furnished to women veterans under contracts entered into that authority.

[“(3) The Secretary may not enter into contracts under this subsection after September 30, 1994. The Secretary shall provide that the authority to furnish care and services pursuant to a contract entered into under this subsection shall expire not later than that date.

[“(c) For the purposes of this section, the term ‘sexual trauma’ means the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, sexual harassment, or other act of sexual violence.”.

[“(b) Clerical Amendment.—The table of sections at the beginning of such chapter is amended by adding after the item relating to section 1720C the following new item:

[“1720D. Care and counseling of women veterans for sexual trauma.”.

[SEC. 3. INFORMATION AND REFERRALS FOR WOMEN VETERANS.

[(a) Information System.—(1) Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall commence the provision of information and referrals relating to the care and services referred to in paragraph (2) by means of a toll-free telephone number (commonly referred to as an 800 number).

[(2) The care and services referred to in paragraph (1) are the care and services relating to sexual trauma that are available to women veterans in the communities in which such veterans reside, including care and services available under programs of the Department of Veterans Affairs (including the care and services available under section 1720D of title 38, United States Code (as added by section 2 of this Act)), and from non-Department agencies or organizations.

[(b) System Requirements.—In providing information and referrals under subsection (a), the Secretary shall ensure that the telephone information system described in that subsection—

[(1) is operated by Department personnel who are trained in the provision of the information and referrals described in that subsection to individuals who have experienced sexual trauma; and

[(2) operates at all times.

[SEC. 4. REPORT ON NEED FOR CARE AND SERVICES ON WOMEN VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

[(a) Report.—Not later than December 31, 1993, the Secretary of Veterans Affairs shall submit to Congress a report on the study carried out by the Secretary under subsection (b).

[(b) Study.—(1) The Secretary, in consultation with and with the assistance of the Secretary of Defense, shall carry out a study of the needs of women veterans for counseling, medical care, and other services for sexual trauma.

[(2) In carrying out the study, the Secretary of Veterans Affairs shall, to the extent feasible, determine the following:

[(A) The extent to which women have experienced rape, other sexual assaults, sexual harassment, or other acts of sexual violence while on active military, naval, or air service.

[(B) The extent to which incidents of rape, other sexual assaults, sexual harassment, or other acts of sexual violence have been under-reported by women in general, by women who are members of the Armed Forces, and by women veterans.

[(C) The extent to which women members of the Armed Forces and women veterans who have experienced sexual trauma have utilized counseling, medical care, and other services furnished by the Department of Defense and the Department of Veterans Affairs in order to respond to such experiences.

[SEC. 5. REPORT RELATING TO SERVICES AVAILABLE TO WOMEN VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

[Not later than December 31, 1992, the Secretary of Veterans Affairs shall submit to Congress a comprehensive report on the care and services furnished by the Department of Veterans Affairs to women veterans who have experienced sexual trauma. The report shall include the following:

[(1) A detailed description and review of the medical care, counseling, outreach, and other services available under programs of the Department of Veterans Affairs to women veterans who have experienced sexual trauma while on active military, naval, or air service, including the number of male and female counselors who have been provided specialized training in the counseling of women.

[(2) An assessment by the Secretary of any deficiencies in such programs in meeting the needs of such veterans for counseling, medical care, and other services in response to such experiences.

[(3) A detailed description of the plans of the Secretary to eliminate such deficiencies, and a schedule for the implementation of such plans.

[SEC. 6. PROVISION OF INFORMATION ON SERVICES TO WOMEN WHO ARE SEPARATING FROM THE ARMED FORCES.

[The Secretary of Defense and the Secretary of Veterans Affairs shall jointly carry out a program to ensure that women who are being separated from active military, naval, or air service are provided information on the counseling, medical care, and other services and assistance relating to sexual trauma that are available to such women under programs carried out by the Department of Veterans Affairs, and the procedures for applying such services and assistance. The Secretary of Defense shall provide such information through an in-person interview conducted with the woman being so separated.

[SEC. 7. REPORT RELATING TO DETERMINATIONS OF SERVICE-CONNECTION FOR SEXUAL TRAUMA.

[(a) Not later than December 31, 1992, the Secretary of Veterans Affairs shall submit to Congress a report containing—

[(1) the Secretary's assessment of—

[(A) the difficulties women veterans encounter in obtaining determinations from the Department of Veterans Affairs that medical conditions relating to sexual trauma are service-connected; and

[(B) the extent to which Department personnel fail to make determinations of service-connection for such conditions; and

[(2) the Secretary's recommendation of actions to be undertaken to respond in a fair manner to such difficulties and to eliminate such failures.

[SEC. 8. DEFINITIONS.

[In this Act:

[(1) The term "active military, naval, or air service" has the meaning given such term in section 101(24) of title 38, United States Code.

[(2) The term "Armed Forces" has the meaning given such term in section 101(10) of title 38, United States Code.

[(3) The term "sexual trauma" means the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, sexual harassment, or other act of sexual violence.]

and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Women Veterans Health Programs Act of 1992".

TITLE I—SEXUAL TRAUMA SERVICES

SEC. 101. CARE AND SERVICES FOR WOMEN VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

(a) REQUIREMENT TO FURNISH CARE AND SERVICES.—Chapter 17 of title 38, United States Code, is amended by adding at the end of subchapter II the following new section:

"§ 1720D. Counseling and treatment of women veterans for sexual trauma

"(a) A woman veteran who is diagnosed by a Department health professional designated by the Chief Medical Director (following an examination of the veteran by such professional) to be in need of counseling or treatment for sexual trauma resulting from events that occurred during the period of the woman veteran's service on

active duty, shall be furnished care and services with respect to such trauma pursuant to sections 1710(a)(1)(A) and 1712(a)(1)(A) of this title, even though such trauma has not been determined to be service-connected.

"(b)(1) The Secretary may enter into contracts with appropriate non-Department facilities (as determined by the Secretary) in order to furnish women veterans with the care and services (including any diagnostic services) referred to in subsection (a).

"(2) Not later than March 31, 1994, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the use made of the authority provided under paragraph (1) before the date of the report. The report shall (A) describe the extent of the use of that authority and the types of care and services furnished to women veterans under contracts entered into under that authority, and (B) contain such recommendations regarding the extension or modification of that authority as the Secretary considers appropriate.

"(3) The Secretary may not enter into contracts under this subsection after September 30, 1994. Any contract entered into under this subsection shall expire not later than 90 days after that date.

"(c) For the purposes of this section, the term 'sexual trauma' means the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, sexual harassment, or other act of sexual violence.".

(b) Clerical Amendment.—The table of sections at the beginning of such chapter is amended by adding after the item relating to section 1720C the following new item:

"1720D. Counseling and treatment of woman veterans for sexual trauma."

SEC. 102. INFORMATION AND REFERRALS FOR WOMEN VETERANS.

(A) Information System.—(1) Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall commence the provision of information and referrals relating to the care and services referred to in paragraph (2) by means of a telephone information system utilizing a toll-free telephone number (commonly referred to as an 800 number).

(2) The care and services referred to in paragraph (1) are the care and services relating to sexual trauma that are available to women veterans in the communities in which such veterans reside, including care and services available under programs of the Department of Veterans Affairs (including the care and services available under section 1720D of title 38, United States Code (as added by section 101 of this Act)) and from non-Department agencies or organizations.

(b) System Requirements.—In providing information and referrals under subsection (a), the Secretary shall ensure that the telephone information system described in that subsection—

(1) is operated by Department personnel who are trained in the provision of the information and referrals described in that subsection to persons who have experienced sexual trauma;

(2) is operated in a manner that protects the confidentiality of persons who place telephone calls to the system; and

(3) operates at all times.

SEC. 103. REPORT ON NEED FOR CARE AND SERVICES OF VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

(a) Report.—Not later than December 31, 1993, the Secretary of Veterans Affairs shall submit to Committees on Veterans' Affairs of the Senate and House of Representatives a report on the study carried out by the Secretary under subsection (b).

(b) Study.—(1) The Secretary, in consultation with and with the assistance of the Secretary of Defense, shall carry out a study of the needs of women veterans for counseling, medical care, and other services for sexual trauma.

(2) In carrying out the study, the Secretary of Veterans Affairs shall, to the extent feasible and to the extent that data are available, determine the following:

(A) The extent to which women have experienced rape, sexual assault, sexual harassment, or other acts of sexual violence while on active military, naval, or air service.

(B) The extent of any under-reporting of incidents of rape, sexual assault, sexual harassment, or other acts of sexual violence among the population of women members of the Armed Forces, and the extent to which the rate of such under-reporting differs from the rate of under-reporting of such incidents among the general population of women in the United States.

(C) The extent to which women members of the Armed Forces and women veterans who have experienced sexual trauma have utilized counseling, medical

care, and other services furnished by the Department of Defense and the Department of Veterans Affairs in order to respond to such experiences.

(D) The same types of information with respect to men who are members of the Armed Forces and men who are veterans as is required under subparagraphs (A), (B), and (C) with respect to women members and veterans.

SEC. 104. REPORT RELATING TO SERVICES AVAILABLE TO VETERANS WHO HAVE EXPERIENCED SEXUAL TRAUMA.

Not later than March 1, 1993, and December 31 of each of calendar years 1993 through 1997, the Secretary of Veterans Affairs shall submit to the Committees on Veterans Affairs' of the Senate and House of Representatives a comprehensive report on the care and services furnished by the Department of Veterans Affairs to veterans who have experienced sexual trauma. The report shall include the following:

(1) A detailed description and review of the medical care, counseling, outreach, and other services available under the programs of the Department to veterans who have experienced sexual trauma resulting from events that occurred during the period of such veterans' service in the active military, naval, or air service, including the number of male and female counselors employed by the Department who have been provided specialized training in the counseling of persons who have experienced sexual trauma.

(2) An assessment by the Secretary of any quantitative or qualitative deficiencies in such programs in meeting the needs of such veterans for counseling, medical care, and other services in response to such experiences.

(3) A detailed description of the plans of the Secretary to eliminate such deficiencies and a schedule for implementation of such plans.

SEC. 105. PROVISION OF INFORMATION ON SERVICES TO WOMEN WHO ARE SEPARATING FROM THE ARMED FORCES.

The Secretary of Veterans Affairs and the Secretary of Defense shall jointly carry out a program to ensure that women who are being separated from active military, naval, or air service are provided information on (1) the counseling, medical care, and other services and assistance relating to sexual trauma that are available to women veterans under programs carried out by the Department of Veterans Affairs, and (2) the requirements of eligibility for or entitlement to, and the procedures for applying for, such counseling, medical care, and other services and assistance. The Secretaries shall ensure that such information is provided through an in-person interview conducted with the woman being separated.

SEC. 106. REPORT RELATING TO DETERMINATIONS OF SERVICE CONNECTION FOR SEXUAL TRAUMA,

(a) Not later than December 31, 1992, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing—

(1) the Secretary's assessment of—

(A) the difficulties that women veterans encounter in obtaining from the Department of Veterans Affairs determinations that disabilities relating to sexual trauma that are the results of events that occurred during active duty are service-connected disabilities; and

(B) the extent to which Department personnel fail to make determinations that such disabilities are service-connected disabilities; and

(2) the Secretary's recommendation of actions to be undertaken to respond in a fair manner to such difficulties and to eliminate such failures.

SEC. 107. DEFINITIONS.

In this title:

(1) The terms "Armed Forces", "service-connected", and "active military, naval, or air service" have the meanings given such terms in paragraphs (10), (16), and (24) of section 101 of title 38, United States Code, respectively.

(2) The term "sexual trauma" means the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, sexual harassment, or other act of sexual violence.

TITLE II—HEALTH CARE FOR WOMEN VETERANS

SEC. 201. WELL-WOMEN CARE SERVICES.

(a) WELL-WOMEN CARE SERVICES.—Section 1701 of title 38, United States Code is amended—

(1) in paragraph (6)(A)(i), by inserting "well-women care services," after "section 1762 of this title,"; and

(2) by adding at the end of the following new paragraph:

"(9)(A) The term 'well-women care services' means health care services provided to women outside the maternity cycle, including counseling and services relating to the following:

"(i) Papanicolaou tests (pap smear).

"(ii) Breast examinations and mammography.

"(iii) General reproductive health care.

"(iv) The management of infertility.

"(v) Menopause.

"(vi) Physical or psychological conditions arising out of acts of sexual violation.

"(B) The term does not include the following services:

"(i) Pregnancy care (including prenatal and delivery care), except care relating to a pregnancy that is complicated, or in which the risks of complication are increased by a service-connected condition.

"(ii) Abortion.".

(b) CONTRACTS FOR WELL-WOMEN CARE SERVICES.—Section 1703(a) of such title is amended by adding at the end the following new paragraph:

"(9) Well-women care services for veterans on an ambulatory outpatient basis, but only under contracts that expire not later than December 31, 1994.".

(c) REPORT ON THE PROVISION OF HEALTH CARE TO WOMEN.—(1) Not later than January 1 of each of 1993 through 1997, the Secretary shall submit to Congress a report on the provision of health care services to women veterans.

(2) The report shall contain the following with respect to the most recent fiscal year before the date of the report.

(A) A description of the personnel of the Department who provided health-care services to women veterans, including the number of employees (including both the number of individual employees and the number of full-time employee equivalents) and the professional qualifications or specialty training of such employees and the Department facilities to which such personnel were assigned.

(B) A description of any actions taken by the Secretary to ensure the retention of the personnel described in subparagraph (A), and any actions undertaken to recruit additional personnel or personnel to replace such personnel.

(C) A description of the type and amount of well-women care services provided by such personnel, including information on—

(i) the type and amount of such services provided at each Department facility;

(ii) the number of women provided such services at each Department facility; and

(iii) the numbers of inpatient stays and the number of outpatient visits through which such services were provided.

(D) A description of the type and amount of well-women care services provided under contracts with non-Department facilities, including information on—

(i) the type and amount of such services provided under each contract;

(ii) the number of women provided such services through each non-Department facility under each contract; and

(iii) the numbers of inpatient stays and the number of outpatient visits through which such services were provided.

(E) An assessment by the Secretary of any difficulties experienced by the Secretary in the furnishing of such services and the actions taken by the Secretary to resolve such difficulties.

(F) A description of the actions taken by the Secretary to foster and encourage the expansion of research relating to health care issues of concern to women veterans.

(3) In this subsection, the term "well-women care services" has the meaning given such term in section 1701(8) of title 38, United States Code (as added by subsection (a)).

SEC. 202. EXPANSION OF RESEARCH RELATING TO WOMEN VETERANS.

(a) EXPANSION OF MEDICAL RESEARCH PROGRAM.—(1) Subject to paragraph (3), in carrying out the medical research program of the Department under section 7303 of title 38, United States Code, the Secretary, in consultation with the Chief Medical Director (who shall consult with the Director of Nursing Service, officials of the Central Office assigned responsibility for women's programs and the program carried out under section 7303, members of the Advisory Committee on Women Veter-

ans established under section 542 of such title, and members of appropriate task forces with the Department of Veterans Affairs (such as the Task Force on Treatment of Women Who Suffer Sexual Abuse)), shall foster and encourage the initiation and expansion of research into the health consequences for women veterans of the matters referred to in paragraph (2).

(2) The Secretary shall foster and encourage the initiation and expansion of research under paragraph (1) on the following matters as they relate to women:

(A) Breast Cancer.
(B) Gynecological and hormonal matters.
(C) Cancer of the organs of the reproductive system.
(D) Alzheimer's Disease.
(E) Osteoporosis.
(F) Post-traumatic stress disorder.
(G) Substance abuse.
(H) Sexual violence.

(b) STUDY OF ADMITTANCE OF VETERANS TO DEPARTMENT MEDICAL CARE FACILITIES.—The Comptroller General of the United States shall carry out a study to determine—

(1) the percentage of all admissions of women veterans to Department facilities that are based on a diagnosis of psychotic illness;

(2) the percentage of all admissions of men veterans to such facilities that are based on a diagnosis of psychotic illness;

(3) an explanation of the difference, if any, in the percentages referred to in paragraphs (1) and (2), including an assessment of—

(A) the extent, if any, to which psychotic illness is more prevalent among women veterans who seek care at Department facilities than among men veterans who seek such care;

(B) the extent to which gender-related factors impede or complicate diagnoses made by Department personnel; and

(C) the extent to which, among veterans with psychotic illness, women and men seek and receive Department health-care services in different proportions.

(c) AUTHORIZATION OF APPROPRIATIONS.—(1) Funds are authorized to be appropriated for the Department of Veterans Affairs to carry out subsections (a) and (b) as follows:

(A) For fiscal year 1993, $1,500,000.
(B) For fiscal year 1994, $2,000,000.
(C) For fiscal year 1995, $2,500,000.

(2) Funds appropriated pursuant to the authorization of appropriations under paragraph (1) are in addition to other funds appropriated or otherwise made available to the Department of Veterans Affairs for research.

SEC. 203. RESEARCH OF THE DEPARTMENT OF VETERANS AFFAIRS RELATING TO WOMENS' HEALTH CARE ISSUES.

Section 7303 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(d)(1) To the extent that the Secretary determines that the quantity and nature of information available to Department personnel with respect to issues relating to health care for women veterans is inadequate to permit such personnel to carry out research relevant to the health-care needs of women veterans, the Secretary shall take actions to ensure that medical raesearch carried out by the Secretary gives consideration to issues relating to the health of the general population of adult women in the United States, with particular emphasis on health conditions that affect large numbers of such women and therefore are likely to be prevalent to a significant degree among women veterans and health conditions for which the risk factor, treatment responses, and other factors determined relevant by the Secretary of women veterans may differ from those of the general population of adult women in the United States.

"(2) to the maximum extent practicable, the Secretary shall ensure that the personnel engaged in research pursuant to the research program described under paragraph (1)—

"(A) include—

"(i) personnel of the Department in facilities of the Department, including personnel of geriatric research, education, and clinical centers designated pursuant to section 7314 of title 38, United States Code; and

"(ii) personnel of the National Center for Post-Traumatic Stress Disorder established pursuant to section 110(c) of the Veterans Health Care Act of 1984 (Public Law 98-528; 98 Stat. 2692); and

"(B) are informed of the existence and progress of other research relating to women veterans conducted by or under the jurisdiction of the Secretary.".

SEC. 204. POPULATION STUDY OF THE NEED OF WOMEN VETERANS FOR HEALTH-CARE SERVICES.

(A) STUDY.—The Secretary shall conduct an ongoing study to determine the needs of women veterans for health-care services.

(2) Before carrying out the study, the Secretary shall—

"(A) request the advice of the Advisory Committee on Women Veterans established under section 542 of title 38, United States Code; and

"(B) in consultation with the Secretary of Defense, request the advice of the Advisory Committee on Women in the Services.

(3)(A) In carrying out the study, the Secretary (with the assistance of the Secretary of Defense) shall—

(i) examine the medical, biopsychoscial, and demographic histories of an appropriate sample of women veterans and women members of the Armed Forces who are serving on action duty;

(ii) to the extent feasible, use data from the most recent decennial census and official census statistics; and

(iii) to the extent feasible, use information contained in the report submitted to the Secretary under section 102(b) of the Veterans' Health Care Amendment of 1983 (Public Law 98-160; 38 U.S.C. 1712A note).

(B) The sample referred to in subparagraph (A)(i) shall include women veterans and women members of the Armed Forces who are serving on active duty and shall, to the extent feasible, provide a representative sampling (as determined by the Secretary) of the ages, the ethnic, social, and economic backgrounds, the enlisted and officer grades, and the branches of service of women veterans and women members of Armed Forces.

(C) The protocol for the study shall meet standards for scientific merit prescribed by the Secretary.

(b) REPORTS.—The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives reports relating to the results of the study as follows:

(1) Not later than 6 months after the date of enactment of this Act, an interim report on the study describing—

"(A) the status of the study on the date of the report; and

(B) the information and advice obtained by the Secretary from the Advisory Committees referred to in paragraph (2)(A).

(2) Not later than April 1, 1994, a report describing the results of the reports as of that date.

(3) Not later than April 1 of each of 1996, 1998, 2000, 2002, and 2004, a report describing the results of the study as of the date of such report.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Department of Veterans Affairs $1,500,000 to carry out the purposes of this section. Amounts appropriated pursuant to this authorization of appropriations shall be available for obligation until expended without fiscal year limitation.

SEC. 205. REPORT ON RESEARCH RELATING TO WOMEN VETERANS.

Not later than July 1 of each of 1993, 1994, 1995, and 1996, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing—

(1) a description (as of May 31 of the year in which the report is submitted) of the status of any research relating to women veterans being carried out by or under the jurisdiction of the Secretary (including the research carried out under section 7303(d) of title 38, United States Code (as added by section 203 of this Act)); and

(2) recommendations of the Secretary as to future research (including a proposal for any legislation relating to such research) relating to women veterans.

SEC. 206. SUPPORT FOR WOMEN VETERANS COORDINATORS.

The Secretary shall take appropriate actions to ensure that—

(1) sufficient funding is provided to each Department facility in order to permit the women veterans coordinator to carry out the functions of the coordinator at the facility;

(2) sufficient clerical and communications support is provided to each such coordinator for that purpose; and

(3) each such coordinator has direct access to the Director or Chief of Staff of the facility to which the coordinator is assigned.

SEC. 207. REGIONAL WOMEN VETERANS COORDINATORS.

(a) REQUIREMENT OF APPOINTMENT.—The Secretary shall appoint a regional women veterans coordinator to serve in each regional office of the Veterans Health Administration. A person appointed as a coordinator under this section shall serve in the position on a full time basis.

(b) RESPONSIBILITIES.—Each regional women veterans coordinator shall—

(1) coordinate the training of women veterans coordinators who are assigned to Department facilities in the region under the jurisdiction of such regional coordinator; and

(2) provide appropriate technical support and guidance to Department facilities in that region with respect to outreach activities to women veterans.

SEC. 208. FUNDING FOR CERTAIN ACTIVITIES OF THE ADVISORY COMMITTEE ON WOMEN VETERANS.

From funds available to the Department of Veterans Affairs, the Secretary shall provide funds to be used for the members of the Advisory Committee on Women Veterans established under section 542 of title 38, United States Code, for the following purposes:

(1) For travel in connection with a reasonable number of visits to Department facilities in order to permit such members to carry out the responsibilities of the Advisory Committee.

(2) For the conduct of meetings of the Advisory Committee.

SEC. 209. DEFINITIONS.

For the purposes of this title—

(1) The term "Secretary" means the Secretary of Veterans Affairs.

(2) The term "Department" means the Department of Veterans Affairs.

(3) The term "Department facilities" means the following facilities at which the Secretary furnishes medical services:

(A) Facilities over which the Secretary has direct jurisdiction.

(B) Government facilities for which the Secretary contracts.

(4) The term "medical services" has the meaning given such term in section 1701(6) of title 38, United States Code (as amended by section 201(a) of this Act).

(5) The term "veteran" has the meaning given such term in section 101(2) of title 38, United States Code.

Amend the title so as to read:

To amend title 38, United States Code, to improve the care and services furnished to women veterans who have experienced sexual trauma while on active duty, to study the needs of such veterans, to expand and improve other Department of Veterans Affairs programs that provide care and services to women veterans, and for other purposes.

INTRODUCTION

On July 2, 1992, S. 2973 was introduced by the Chairman of the Committee, Senator Alan Cranston, and co-sponsored by Committee members Dennis DeConcini, John D. Rockefeller IV, Bob Graham, Daniel K. Akaka, Thomas A. Daschle, James M. Jeffords, and Senators Paul Simon and John F. Kerry. Joining later as co-sponsors were Committee member George J. Mitchell, and Senators Edward M. Kennedy, Alan J. Dixon, Kent Conrad, Barbara Mikulski, and the late Senator Quentin N. Burdick. As introduced, S. 2973 would, among other things, amend title 38, United States Code, to improve the care and services furnished to women veterans who have experienced sexual trauma while on active duty, to study the needs of such veterans, and to expand and improve other Department of Veterans Affairs programs that provide such care and services.

Previously, on November 22, 1991, the Ranking Republican Member of the Committee, Senator Arlen Specter, introduced S. 2028, the proposed "Women Veterans' Health Equity Act of 1991".

Joining later as cosponsors were Committee Members Akaka and Jeffords and Senators Daniel K. Inouye, Ted Stevens, Dave Durenberger, Thad Cochran, Richard C. Shelby, John McCain, and J. Bennett Johnston. As introduced, S. 2028 would make improvements and expansions in the health-care services VA provides to women veterans.

The Committee held three hearings on the overall health-care needs of women veterans, including specifically the needs of women veterans who experienced sexual trauma while serving on active duty.

On June 19, 1992, Senator Specter chaired a field hearing in Pittsburgh, Pennsylvania. Testimony on S. 2028 was received from Thomas Gigliotti, Director, University Drive VA Medical Center, Pittsburgh, Pennsylvania; Reedes Hurt, Director, Highland Drive VA Medical Center, Pittsburgh, Pennsylvania; David P. Baine, Director, Federal Health-Care Delivery Issues, Human Resources Division, U.S. General Accounting Office; Lieutenant Colonel Beverly A. Albaugh, U.S. Army, Retired; Ginger Ruckman, Commander, Disabled American Veterans, Chapter 73, Erie, Pennsylvania; and Marsha Four, member of Vietnam Veterans of America National Women's Coalition.

On June 30, 1992, Senator Cranston chaired a hearing on the treatment and other needs of women veterans who experienced sexual trauma while on active duty and VA's capacity to meet those needs. Testimony was received from Diana Danis, Executive Director, National Women Veterans Conference; Wendy J. Freitag, Ph.D., Acting Chairperson, VA Readjustment Counseling Service Women Veterans Working Group, Milwaukee Vet Center; Jessica Wolfe, Ph.D., Associate Director, Department of Veterans Affairs, National Center for PTSD, Behavioral Science Division, Boston, Massachusetts; Joan Furey, R.N., M.A., Associate Director, Department of Veterans Affairs, National Center for PTSD, Behavioral Science Division, Menlo Park, California; Susan Angell, M.S.W., Ph.D., Manager, Department of Veterans Affairs Readjustment Counseling Service, Pacific Western Regional Office; Marvin Abney, Ph.D., Outpatient Psychiatric Center, Audie Murphy VA Medical Center, San Antonio, Texas; Mary P. Koss, Ph.D., representing the American Psychological Association; Christine A. Courtois, Ph.D., Clinical Director, Center for Abuse Recovery and Empowerment, Psychiatric Institute of Washington, D.C.; Dean G. Kilpatrick, Ph.D., Professor of Clinical Psychology, Medical University of South Carolina, Charleston; and three survivors of sexual assault in the military, Barbara Franco, Jacqueline Ortiz, and Mary Kelley Richard.

On July 2, 1992, Senators Cranston and Specter chaired a hearing in Washington, D.C., on women veterans' health care in general, including S. 2028, and on the needs of women veterans who experienced sexual trauma while serving on active duty. Testimony was received from James W. Holsinger, Jr., M.D., Chief Medical Director, Department of Veterans Affairs; representatives of The American Legion, the American Nurses Association, the Disabled American Veterans, the Nurses Organizations of Veterans Affairs, and the Vietnam Veterans of America; Shirley Menard, R.N., M.S.N., Assistant Professor, University of Texas Health Science

Center, School of Nursing, and Chairperson, VA Advisory Committee on Women Veterans; Margaret Kruckmeyer, R.N., M.S.N., M.A., Oncology Nurse Specialist, Dayton, Ohio, VA Medical Center; Josephine Magness, B.S.N., M.P.H., Women Veterans Coordinator and Special Assistant to the Director, Baltimore, Maryland, VA Medical Center; and Carmencita Turner, B.S.N., M.A., Women Veterans Coordinator and Head Nurse, I.V. Therapy Team, Washington, D.C., VA Medical Center.

Following the Committee's June 30 hearing, Chairman Cranston introduced S. 2973 to improve the services VA provides to women veterans who experienced sexual trauma while serving in the military. The Committee received written testimony from witnesses at the June 30 and July 2 hearings regarding the issues subsequently included in S. 2973 as introduced.

COMMITTEE MEETING

After carefully reviewing testimony related to the health-care needs of women veterans, including specifically the needs of women veterans who experienced sexual violence while on active duty and the witnesses' views on the provisions of S. 2028 and the issues addressed in S. 2973, the Committee met in open session on August 7, 1992, and voted by voice vote to report S. 2973 favorably to the Senate with an amendment in the nature of a substitute, incorporating provisions derived from S. 2973 as title I, Sexual Trauma Services, and provisions derived from S. 2028 as title II, Health Care for Women Veterans.

Summary of S. 2973 as Reported

S. 2973 as reported (hereinafter referred to as the "Committee bill") includes amendments to title 38, United States Code, and free-standing provisions that would:

TITLE I—SEXUAL TRAUMA SERVICES

1. Require VA, in the case of a woman veteran whom a designated VA health-care professional has found to be in need of counseling or treatment for sexual trauma that occurred during service, to provide the woman veteran with health-care services necessary in connection with the trauma on the same basis as VA is required to provide care for service-connected disabilities. (Section 101.)

2. Authorize the Secretary of VA, through December 31, 1994, to furnish these services through contracts with non-VA providers and require the Secretary to provide to the Senate and House of Representatives Veterans' Affairs Committees by March 31, 1994, a report on the use of this authority. (Section 101.)

3. Require VA to provide for women veterans a toll-free, 24-hour information and referral telephone line, staffed by personnel trained to facilitate access to services relating to sexual trauma. (Section 102.)

4. Require the Secretary of VA, in cooperation with the Secretary of Defense, to carry out and submit to the Congress by December 31, 1993, a study of the extent of veterans' needs for counseling, medical care, and other services as the result of experiencing rape, other sexual assault, or sexual harassment while serving on active

duty, including the extent of sexual trauma experienced in the military service, the extent of underreporting of crimes of sexual violence in the Armed Forces, and the utilization of military and VA health-care services by servicemembers and veterans, respectively, who were the victims of rape, other sexual assault, or sexual harassment. (Section 103.)

5. Require the Secretary of VA, by March 1, 1993, and by December 31 of each of calendar years 1993 through 1997, to provide the Veterans' Affairs Committees with a comprehensive report on VA services for veterans who experienced sexual trauma, including (a) information on medical care, counseling, outreach, and other services, and the numbers of male and female counselors provided specialized training in the counseling of women who have experienced sexual trauma; (b) an assessment of any deficiencies in meeting the veterans' needs; and (c) plans to correct those deficiencies. (Section 104.)

6. Require the Secretaries of VA and Defense jointly to ensure that all women being separated from active duty are given appropriate, in-person advice (a) regarding the availability of VA counseling, medical care, and other services and assistance with respect to sexual trauma; and (b) the requirements for eligibility for or entitlement to, and the procedures for applying for, such counseling, medical care, and other services and assistance. (Section 105.)

7. Require VA to submit to the Veterans' Affairs Committees by December 31, 1992, a report on (a) the difficulties veterans encounter in obtaining VA determinations that disabilities relating to sexual trauma that are the results of events that occurred during active duty are service connected and the extent to which VA fails to make determinations that such disabilities are service-connected; and (b) what steps should be taken to respond in a fair manner to those difficulties and to eliminate these failures. (Section 106.)

TITLE II—HEALTH CARE FOR WOMEN VETERANS

1. Add "well-women health care services" to the definition of "medical care" in section 1701 of title 38, thereby authorizing the Secretary, in furnishing care and services to women veterans under chapter 17, to furnish health-care counseling and services with respect to physical and psychological conditions which may affect the current or future physical or psychological health of the veteran even though such counseling and services may not be considered to be the care or treatment of a disability nor preventive health-care services. (Section 201.)

2. Define the term "well-women care services" to mean health care services provided to women outside the maternity cycle, including counseling and services related to (a) Papanicolaou tests (pap smears), (b) breast examinations and mammography, (c) general reproductive health care, (d) the management of infertility, (e) menopause, and (f) physical or psychological conditions arising out of acts of sexual violence, but specifically exclude from the definition (a) pregnancy care (including prenatal and delivery care), except in those cases in which the risks of complications of pregnancy or pregnancy outcome are increased secondary to a service-connected condition, and (b) abortion. (Section 201.)

3. Authorize the Secretary to contract with non-VA entities for the furnishing of well-women services on an outpatient basis, under contracts that expire not later than December 31, 1994. (Section 201.)

4. Require the Secretary to submit an annual report (on January 1 of each of 1993 through 1997) providing (a) information on the extent of well-women health-care services provided by VA personnel or under sharing or contract agreements, (b) the numbers of individuals and the full-time employee equivalents supporting such services, (c) an assessment by the Secretary of any difficulties in furnishing such services and the actions and plans taken to resolve such difficulties, and (d) a description of the Secretary's efforts to foster and encourage the expansion of research involving health-care concerns of women veterans. (Section 201.)

5. (a) Require the Secretary to foster and encourage research involving the health-care concerns of women veterans in consultation with the Chief Medical Director (who would be required to consult with the Director of Nursing Service, the Central Office officials assigned responsibilities for women's programs and the operation of VA's research program, the Advisory Committee on Women Veterans, and relevant task forces within the Department, such as the Task Force on Treatment of Women Who Suffer Sexual Abuse), with respect to breast cancer, gynecological and hormonal matters, cancer of the organs of the reproductive system, Alzheimer's Disease, osteoporosis, post-traumatic stress disorder, substance abuse, and sexual violence; and (b) authorize the appropriation to VA of $1.5 million, $2 million, and $2.5 million for fiscal years 1993 through 1995, in addition to the appropriations that are otherwise appropriated for VA research, to be made available for research relating to health issues relating to women veterans. (Section 202.)

6. Require the Comptroller General of the United States to study the differences in proportionate psychotic diagnoses among male and female admissions to VA health-care facilities, including exploration of differences in symptom prevalence, gender-related diagnostic difficulties, and gender-associated use of VA health-care services. (Section 202.)

7. Require the Secretary, to the extent that information available to VA personnel with respect to issues relating to health care for women veterans is inadequate to permit them to carry out research relevant to the health-care needs of women veterans, to take action to ensure that VA's medical research gives consideration to issues relating to the health of the general population of adult women in the United States, giving particular consideration to health conditions affecting (a) large numbers of women in general and (b) women veterans in particular because of those veterans' risk factors, treatment responses, and other relevant factors. (Section 203.)

8. Require the Secretary, in conducting research relating to womens' health care issues, to (a) include personnel of VA's Geriatric Research, Education and Clinical Centers (GRECCs) and the National Center for PTSD, and (b) ensure that VA researchers are informed of the existence and progress of other VA research relating to women veterans. (Section 203.)

9. (a) Require the Secretary to conduct an ongoing population study of women veterans' health-care-services needs (after request-

ing the advice of the VA Advisory Committee on Women Veterans and the Department of Defense Advisory Committee on Women in the Services); and (b) require the Secretary, in carrying out this population study, to examine the medical, biopsychosocial, and demographic histories of an appropriate sample of women veterans and (with the assistance of the Secretary of Defense) women members of the Armed Forces who are serving on active duty; (c) require the Secretary to submit a series of reports, through April 1, 2004, to the Committees on Veterans' Affairs of the Senate and House of Representatives on that study; and (d) authorize the appropriation of $1.5 million for the study. (Section 204.)

10. Require the Secretary to submit to the Committees on Veterans' Affairs of the Senate and House of Representatives, by July 1 of each of 1993 through 1995, a report which includes (a) a description of the status of any VA research relating to women veterans and (b) the recommendations of the Secretary as to future research (including a proposal for any legislation relating to such research) relating to women veterans. (Section 205.)

11. Require the Secretary to provide (a) sufficient funding to enable Women Veterans Coordinators (WVC) at each VA medical center to carry out their functions, (b) provide the WVCs with adequate clerical and communications support, and (c) ensure that each WVC has direct access to the Director or the Chief of Staff of the medical center where the WVC is assigned. (Section 206.)

12. Require the Secretary to appoint a full-time Regional Women Veterans Coordinator at each Veterans Health Administration regional office to coordinate the training of WVCs based at health care facilities within the region and provide technical support and guidance with respect to outreach to women veterans. (Section 207.)

13. Require the Secretary to make available funds to support (a) reasonable site visits to VA facilities by members of the Advisory Committee on Women Veterans, and (b) meetings of the Committee.

Discussion

TITLE I—SEXUAL TRAUMA SERVICES

Background

The issues surrounding VA's ability to counsel and treat victims of rape, sexual assault, and sexual harassment came to the Committee's attention in April 1992 when the Committee learned of the experiences of a woman veteran who had been raped while on active duty. When, several years after the incident occurred, she sought VA treatment, VA's initial response was highly inadequate. In fact, the VA facility at which she sought service initially rejected her request because the staff did not know how to care for her. Although VA eventually contracted for community counseling services for this veteran, the lack of any pre-established helpful form of VA response remains most distressing to the Committee.

At about the same time, an article in the April 1992 issue of the Disabled American Veterans magazine referred to the difficult situations faced by women veterans who experienced sexual violence in the service. This article reported on the concerns of women, in-

cluding those of the National Women Veterans Conference, of which Diana Danis is the Executive Director, and made the following point:

> "Throughout all the meetings the conference has held, when the subject of sexual assault comes up, I've found that only a very small handful of women were not assaulted during their military career," said Danis. Women often wait years before seeking treatment because while they are in the military, they are encouraged to "sweep it under the rug," of if they do bring the incident to the attention of their superiors, the male is usually protected and the woman is transferred.

Further, according to the article, Ms. Danis said that women veterans do not receive treatment if they approach VA because there is a lack of documentation in their service records that the incident occurred during active duty.

The number of sexual assaults and rapes that occur in the military have been and continue to be largely unknown and is difficult to establish. The services do not maintain consistent data on sexual violence. Some military bases record the number of sexual assault and rape complaints lodged, others record the number of complaints investigated, while others record the number of investigations completed where the alleged assailant is charged with sexual assault or rape. Moreover, victims of sexual violence in the civilian community tend not to report the crime and there is good reason to believe that the degree of underreporting is more pronounced in the military.

The most extensive reliable information the Committee found on the extent of the problem in the military is in a September 1990 Defense Manpower Data Center report entitled "Sexual Harassment in the Military: 1988," to which approximately 12,500 active-duty military women responded. Five percent of the respondents reported actual or attempted rape or sexual assault during the most recent twelve months. If that percentage is applied to the approximately 222,000 women on active duty in 1988, over 11,000 women in the military could have been victims of sexual violence in that one year.

Given the extent of the problem within the military, the implications for VA are astounding. There are currently 1.2 million women veterans. Applying the 5-percent figure to this population—a percentage that may well be conservative, since women veterans' periods of service average approximately 7 years, in contrast to the one-year period covered by the study—would indicate that 60,000 women veterans were raped or otherwise sexually assaulted during their service.

Other data suggest the possibility of a dramatically higher incidence of the problem. At the Committee's June 30 hearing, Jessica Wolfe., Ph.D., of VA's National Center for PTSD division located in Boston, reported the results of a study she and Joan Furey, R.N., of the VA's National Center for PTSD division located in Menlo Park, California, had conducted. The study involved 113 women Vietnam theater veterans who served in Vietnam between 1964 and 1975 and who volunteered for the study. These women were surveyed on

a range of psychological and PTSD symptoms as well as on self-reported health problems. Dr. Wolfe reported that, of the 113 female Vietnam veterans, 29 percent experienced a sexual encounter accompanied by force or the threat of force during their service. Susan Angell, M.S.W., Ph.D., Manager of the VA's Readjustment Counseling Service (RCS), Pacific Western Regional Office, testified that an informal survey of two VA RCS regions found that out of a total of 173 women who were clients in February 1992, 30 percent had reported a history of sexual assault during active duty, and an additional 18 percent reported post-service assault.

The number of women in the service and, hence, the number of women veterans, has risen dramatically in recent years. The current 1.2 million women veterans are approximately 4.6 percent of the total veteran population. This percentage is growing as the number of women in the military continues to rise. Women now comprise 12 percent of the active-duty military force, a percentage that will continue to increase as the role of women in the service continues to expand.

VA Responses to Committee Inquiries: On June 12, 1992, the Committee sent a questionnaire to 363 VA facilities—161 VA medical centers, 195 VA Vet Centers, 6 VA independent outpatient clinics, and the one independent VA domiciliary—to determine, among other things, (1) VA facilities' perceptions of the need among women veterans for treatment and counseling for sexual trauma which occurred during active duty, (2) the number of women veterans currently being treated for problems resulting from sexual assaults and rape that occurred while on active duty, (3) the number and qualifications of VA staff trained to counsel women veterans who are survivors of sexual trauma, (4) the number of facilities which have or are planning outreach programs to ensure that women veterans who were victims of sexual trauma during active-duty service apply for VA benefits, and (5) whether VA facilities believe they should provide needed services directly or through contracts with community services. Eighty-six percent of all VA facilities responded to the questionnaire—81 percent of the medical centers, 91 percent of the Vet Centers, and 67 percent of the outpatient clinics (the independent domiciliary did not respond to the questionnaire). (See appendix for a summary of questionnaire responses.)

Senator Cranston sent a letter containing similar questions to Secretary of Veterans Affairs Edward J. Derwinski on June 10, 1992, to request information in preparation for hearings on this issue. Secretary Derwinski responded in a July 28 letter.

Sixty-five percent of the VA facilities that responded to the questionnaire stated they had reason to believe there is a substantial need among women veterans for sexual-abuse treatment or counseling as a result of incidents that occurred during their military service. The majority of respondents stated that they held this belief as a result of reports of research or other means that sexual trauma is or was a substantial problem in the military. (See appendix, tables 2 and 3.)

Secretary Derwinski's July 28 response indicated his view that there is increasing evidence that sexual trauma is more widespread than once thought. He referred to a report on civilian women

which showed that 13 percent of all American women have experienced sexual trauma and assault and nearly one-third of the victims experienced post-traumatic stress disorder (PTSD) at some point in their lives. Further, he cited the results of research from VA's National Center for PTSD (noted above) which indicates that as many as 30 percent of women veterans who volunteered for the National Center's study suffered assaults during their military career but that most of the women had never revealed the trauma or sought treatment for subsequent symptoms. However, the Secretary stated that VA needs better tools to determine the extent of the problem in the military and the number of women suffering from the aftereffects of sexual violence, and he noted that VA has not conducted studies focused on women veterans who have been sexually abused during military service.

According to the information received from VA facilities in response to the questionnaire, few women receive any mental-health counseling at VA facilities. Further, according to approximately 30 percent of questionnaire respondents, very few of the women veterans receiving mental-health treatment or counseling at VA facilities stated that they were raped or otherwise sexually abused during their military services. The remaining medical centers did not know how many women veterans reported such occurrences. In fiscal years 1990, 1991, and 1992-to-date, 11 percent, 10 percent, and 12 percent, respectively, of medical centers responding to the questionnaire stated that no women veterans in counseling reported that they had been raped or sexually assaulted while on active duty; 14 percent, 19 percent, and 24 percent, respectively, stated that 1 to 25 women reported such occurrences. There was no indication that women veterans receiving mental health counseling or treatment are asked whether they have suffered incidents of sexual violence.

Approximately 70 percent of Vet Center respondents furnished information about the number of women veterans in counseling who stated they had been raped or sexually abused while on active duty. Of all Vet Centers that responded to the questionnaire, in fiscal years 1990, 1991, and 1992-to-date, 33 percent, 34 percent, and 37 percent, respectively, stated that no women veterans reported such occurrences; 32 percent, 39 percent, and 42 percent, respectively, stated they were counseling from 1 to 10 women veterans who had experienced rape or sexual assault while on active duty; and, in 1992-to-date, one percent of the Vet Centers stated that they were treating from 11 to 20 women veterans who reported such occurrences.

Secretary Derwinski reported in his July 28 letter that approximately 2,320 women veterans are seen by Vet Centers annually.

Most VA facilities—84 percent of those responding—indicated that they had health-care personnel qualified to counsel women who requested services for the aftereffects of sexual violence. (See appendix, table 6.) When asked to describe the individual staff members' qualifications that are specifically related to counseling for sexual abuse, among other responses, 25 percent of all facilities stated that these staff members were psychologists, 24 percent stated these staff members were social workers with a masters degree, and 37 percent stated these staff members had training in

sex abuse counseling. (See appendix, table 7.) It is unclear whether the latter category is mutually exclusive of the other categories. Sixty-five percent of all respondents stated that they have persons on their staff who have received special training in order to enable them to respond effectively to women who need treatment or counseling as a result of sexual abuse. However, the questionnaire did not examine the scope or depth of the training provided.

In response to a post-hearing question from Senator Cranston concerning the scope and depth of training, Secretary Derwinski indicated that VA did not have that information and was in the process of developing a directory of clinicians "who have special training or experience in treating women victims of sexual abuse," which he expected to provide more detail about the training VA clinicians have received. Secretary Derwinski also agreed that graduate training for psychiatrists, psychologists, and other mental health professionals does not routinely include the specialized training needed for counseling women who have been the victims of sexual violence. He added that, although the treatment of PTSD is taught, "the specialized aspects for treating victims of sexual violence has become an area of significant clinical research interest within the past few years."

Secretary Derwinski stated in his July 28 letter that, since 1986, all of the Mental Health and Behavioral Science Service's training on PTSD has included issues of "special populations" with PTSD, which includes women. However, the focus of this training is on PTSD in general and not specifically related to trauma resulting from sexual violence.

According to the questionnaire responses, the average numbers of male and female counselors working in VA facilities were almost equal, 3.8 and 3.64, respectively. However, there were more female counselors than male counselors in outpatient clinics and the ratio of male counselors to female counselors was greater in Vet Centers than medical centers.

Also, according to the responses to the questionnaire, it appears that few VA facilities have implemented or are planning to implement outreach programs to ensure that women veterans who were victims of sexual trauma during active-duty service apply for any VA benefits or services that they may need as a result. (See appendix, table 9.) However, Secretary Derwinski, in his July 28 letter, stated that VA and other agencies set aside time to talk with all servicemembers concerning their individual problems as they go through the Transition Assistance Program (TAP)—a program conducted by the Departments of Labor, Defense, and Veterans Affairs to educate departing servicemembers about employment and other benefits. Secretary Derwinski stated that women servicemembers would be advised about appropriate VA benefits and claims assistance during private sessions held during these routine briefings. However, he did not supply any data regarding the number of women servicemembers who take advantage of these briefings. In addition to the TAP program, Secretary Derwinski also indicated that outreach programs to let the community and women veterans know that VA can meet their needs, will be carried out after VA personnel are given further training to enable them to do so.

When asked the best method to furnish counseling services for sexually-abused women veterans, respondents to the questionnaire stated there should be a choice of VA providing the services directly or contracting with community agencies, depending upon the case. (See appendix, table 10.) Secretary Derwinski stated that a combination of approaches will be necessary in the foreseeable future because of the small numbers currently seeking treatment from VA, the uneven distribution of women at risk, and the lack of research currently available specifically addressing women who were assaulted in the military.

Committee hearings

On June 30 and July 2, 1992, the Committee held hearings to address the counseling and other needs of women veterans who were sexually assaulted or harassed while on active duty and VA's ability to respond to these needs. Testimony was received from women veterans who were victims of sexual trauma, experts in the counseling and treatment of sexual trauma victims, VA clinicians, VA officials, and veteran's organizations. There was agreement among the witnesses that victims of sexual trauma frequently do not report acts of sexual violence. Further, various witnesses testified that, although counseling and treatment of women veterans who are victims of sexual violence is similar to the counseling and treatment for PTSD from exposure to combat, the counseling and treatment of such women veterans is unique and requires personnel with specialized skills. Those testifying also believed that, although VA has made some progress, it is ill-prepared to care appropriately for women veterans who are victims of sexual violence.

At the June 30 hearing, four women veterans who were victims of sexual trauma while on active duty testified that they reported the assaults to military supervisors. In each case, these veterans told the Committee that their complaints were disregarded or met with indifference. Barbara Franco, a Vietnam-era veteran, testified that she was raped while stationed at Fort Lee, Virginia. She stated that, when she reported the incident, her commanding officer said, "What did you expect? You're not even wearing a bra." Ms. Franco continued, "My friend asked if he [our commanding officer] would call the MPs [military police]. He said no and told us to get out of his office. I did not attempt to report the rape to anyone else after this." When questioned further as to why she did not seek medical attention or counseling in the service, Ms. Franco responded:

> I think of that time as very similar to survivors of concentration camps. Asking why we didn't report it or why we didn't seek medical treatment for the sexual assaults is sort of like asking a prisoner of war or a person in a concentration camp why they didn't report against the guards or why they didn't seek medical treatment while they were being tortured. It sort of feels like being held captive because you've signed up for the time, you belong to the Army.

Mary Kelley Richard, who served in the Coast Guard from 1974 to 1981 and who was sexually assaulted in 1975, testified that she

was not believed when she reported the incident to her Coast Guard school instructor. She indicated that she was afraid to take the complaint further because she feared retaliation.

Diana Danis, who served in the Army from 1973 to 1978, testified that she was raped within four months of joining the service. When she reported the incident to the company commander, she said she was told to forget about the whole thing and was not allowed to go on sick call for a full examination because "she looked okay."

Jacqueline Ortiz, a Persian Gulf War veteran, testified that, after she reported being sexually assaulted by her first sergeant while in Saudi Arabia in January 1991, she was interrogated by investigators and initially reprimanded for sexual improprieties. Subsequently, she was absolved of all charges of wrongdoing when her assailant confessed.

Based on testimony at the hearings and other information gathered as part of the Committee's investigation, the fact that these women servicemembers took even those steps to report the sexual assault appears to be unusual. Dean Kilpatrick, Ph.D., Professor of Clinical Psychology and Director of the Crime Victims Research and Treatment Center, Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, testified at the June 30 hearing that nonreporting of rape and other sexual assault among American women is high and is likely to be at least as high among military women. Data from the 1992 National Women's Study, a longitudinal survey of a large national probability sample of approximately 4,000 American women directed by Dr. Kilpatrick, indicate that only 16 percent of all forcible rape cases were ever reported to police or other authorities. Dr. Kilpatrick believes that rape is not reported because women believe that their privacy will not be protected and that they will be blamed for the attack. Christine Courtois, Ph.D., Clinical Director of the Center for Abuse Recovery and Empowerment, Psychiatric Institute of Washington, D.C., concurred with that assessment. She testified that, in her view, women servicemembers also would be reluctant to report incidents of sexual trauma to a largely male command and to fear blame, disbelief, ridicule, or minimization.

Three of the four women veterans who testified indicated that they attempted to obtain VA counseling and treatment in connection with their assault. Two had difficulty gaining access to the system and all three testified that VA staff were unprepared to counsel and treat them once they did gain entry into the system. Ms. Franco first sought counseling services from a private psychiatrist. When she did go to the VA for care, it was the result of seeing an article about the experiences of women Vietnam veterans that she found at the VA Vet Center where she was employed. However, when she approached another Vet Center for counseling, she was told that she was ineligible for services because she was a program employee. She finally received counseling services from a psychologist at a third Vet Center but discontinued care when he transferred to another VA facility. She stated that she was afraid to go to the VA medical center because the men veterans waiting for care stared at her and sometimes made sexually abusive comments. Ms. Franco currently receives counseling services at a VA

medical center but testified that she does so only because she has come to trust one specific VA psychologist.

Ms. Richard testified that, following her assault, she suffered a stress reaction called psychogenic amnesia, which involves repressing the trauma and most of the events immediately preceding and following it. After discharge from the Coast Guard she began suffering from sleep deprivation and other emotional problems. She sought counseling at a private clinic where she was diagnosed as having PTSD related to sexual violence, but, when she approached VA, a VA benefits counselor told her that delayed stress was only compensated in combat veterans. As a result, she believed she was not eligible for health-care benefits. Later, when she finally obtained entrance into the VA system with the help of a veterans' service organization representative, she described how she was sent from one hospital to another because there were no outpatient or inpatient services available for women veterans who were victims of PTSD as a result of sexual trauma while on active duty. According to her testimony, one inpatient unit to which she finally was admitted was overcrowded and understaffed. While on that unit, she observed another woman being knocked to the floor in the dining room by an angry male patient, and she stated that no staff moved to assist that woman veteran. Ms. Richard finally received counseling and treatment at a private facility. When asked if she believed that Vet Centers and VA medical centers are conducive to women veterans who are seeking counseling or treatment as a result of their being assaulted or raped, she responded, "I don't believe they are by any stretch of the imagination. I have been to seven of them and I don't believe they are."

Ms. Ortiz's testimony indicated that her experience also was unsatisfactory. She testified that the male social worker assigned to her care was insensitive to her needs: "He was trying to help me cope with PTSD related to combat—and not to rape or assault." As a result of this experience and the distance she lives from a VA medical center, she is seeking counseling closer to her residence at her own expense.

Three experts testifying at the June 30 hearing—Drs. Courtois and Kilpatrick and Mary P. Koss, Ph.D., of the University of Arizona Medical School, testifying on behalf of the American Psychological Association—agreed that counselors who treat women victims of sexual trauma need special training. Dr. Courtois testified—and the other two experts agreed—that the treatment of victims of sexual violence usually is not provided in formal educational courses which lead to a degree in the various counseling disciplines. (As noted earlier, Secretary Derwinski in response to a post-hearing question, also agreed with that statement.) In response to a follow-up written question from Senator Cranston, Dr. Courtois wrote that "trainees need very detailed information on myths and misperceptions about abuse and on the attitudes, knowledge base, and interventions which are helpful to victims of such assault." In response to a follow-up written question from Senator Cranston about training, Dr. Koss wrote that "treatment techniques that are successful in the treatment of combat-induced PTSD symptoms are also successful in treating rape-induced PTSD symptoms," but she

added that treatment furnished to rape victims must include other forms of therapy.

These expert witnesses also agreed that problems arising from sexual trauma can appear years after the original incident. Dr. Kilpatrick testified:

> [I]t is apparent that most rape victims experienced some improvement within two to three months after a rape occurs. However, it is equally clear from our research and that of others that many rape victims carry the psychological scars of rape with them for their entire lives.

According to Dr. Courtois, the aftermath of rape can include fear, agitation, sleep disturbance, nightmares, depression, anxiety, confusion, shame and self-blame, inability to concentrate, rumination, mistrust, relational disturbances, sexual distress, skeletal and muscle tension, gastrointestinal and genitourinary irritability, and reactions to physical injury and damage. Dr. Koss stated that the hallmark of PTSD is the intrusive re-experiencing of the trauma. She indicated that women who were raped or were crime victims and had experienced a life threat or physical injury were 8.5 times more likely than other women to experience PTSD. Additionally, Dr. Koss reported, rape is more likely to induce PTSD than other extraordinary events, women with a history of victimization by rape report more symptoms of illness across virtually all body systems, and these women are more likely to report harmful health behaviors including smoking and alcohol abuse. Dr. Koss also noted that victims of sexual violence visit the doctor twice as often as nonvictims, incur greater outpatient medical expenses, and are more likely than nonvictims to suffer from chronic pain symptoms.

Dr. Koss stated that, although rape victims have similarities to other PTSD sufferers, they also differ. First, unlike natural disaster or combat events which are impersonal, rape is perceived as a major violation in trust because it is perpetrated most often by persons known to the victim. Second, the effects of rape may be compounded by a history of sexual abuse as a child. Third, recovery from rape—although achievable with treatment—is difficult because victims must regain their trust, self-efficacy, and sense of control within a society in which women are often implicated for the provocation of sexual assaults against themselves and where discrimination against women continues.

At the July 2 hearing, James W. Holsinger, Jr., M.D., VA Chief Medical Director, in response to a question as to whether he was satisfied with VA's current capability to treat and counsel such women veterans, stated that he was not fully satisfied and noted:

> We have recognized over the past 6 to 8 months * * * that the possibility of having additional indicators that would bring forth women veterans who have been sexually abused or sexually assaulted in the military would come our way. We have undertaken educational endeavors in order to begin the process of making sure that our health-care professionals are fully aware of their need to be able to care for women with such trauma. So although we are

> underway, we are not at the end point yet. We have a ways yet to go, and we're committed to finishing the task.

Training needs were an area highlighted by many of the witnesses, including two other VA officials, Arthur Blank, M.D., Director of VA's Readjustment Counseling Service, and Lawrence Lehmann, M.D., Associate Director for Psychiatry of VA's Mental Health and Behavioral Sciences Service. According to these witnesses, special training is needed beyond that currently provided to mental-health counselors. Dr. Lehmann added:

> [O]ur educational efforts are going to focus not only on our mental health personnel, but also in terms of sensitizing the other medical and surgical clinicians in our VA health-care facilities to identifying the kinds of problems that our female veterans can present, including those individuals who present initially with physical disorders and physical complaints, so that we do not overlook some of the psychological aspects and may be able to uncover issues of those individuals who have suffered sexual abuse.

Committee Bill

Care and Services for Women Veterans Who Have Experienced Sexual Trauma

Section 101 of the Committee bill, which is derived from section 2 of S. 2973 as introduced, would amend chapter 17 of title 38 by adding at the end of subchapter II a new section 1720D. Under subsection (a) of this new section, VA would be required to provide a woman veteran who has been diagnosed by a health-care professional (designated by the Chief Medical Director) to be in need of counseling or treatment for sexual trauma that occurred during service with all health-care services necessary in connection with the trauma on the same priority basis as VA is required to provide for service-connected disabilities. For purposes of this eligibility for care, "sexual trauma" is defined to mean the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, sexual harassment, or other act of sexual violence.

Under current law, veterans, including women veterans, generally are entitled to all health-care services necessary for the treatment of service-connected disabilities or, if they have service-connected disabilities rated at least 50-percent disabling, for any disability. Other veterans seeking care for non-service-connected disabilities may be entitled to inpatient care, but not necessarily to any outpatient care they need, if they have a service-connected disability rated at less than 50 percent or if their income is below certain specified levels. Other veterans may apply for VA care, but VA generally is not required to furnish it unless resources are available. Unless a veteran is entitled to care, there are no assurances that VA can furnish it. As a result, it is very important under current law that a veteran with a disability related to the servicemember's active duty establish that disability as service connected.

The most compelling evidence that would establish that a disability is service connected is a reference in the servicemember's mili-

tary record to the illness or injury which caused the disability. Other kinds of proof may exist, such as statements from witnesses, which might provide the necessary link between a current disability and military service; but such alternative forms of evidence frequently are difficult to produce or are open to question.

As discussed above, it is clear that civilian women who have been victims of rape or sexual assault frequently do not report the incident to police or other authorities. According to the National Women's Study, an ongoing study being conducted by the National Victim Center and the Crime Victims Research and Treatment Center, 84 percent of women who were raped do not report the incident to the police. There is no reason to believe that women servicemembers differ from their civilian counterparts. Indeed, the Committee heard testimony that suggested that women on active duty may be even less likely to report crimes of sexual violence. Witnesses suggested that women servicemembers often do not report incidents of sexual violence when it occurs because they fear that (1) the perpetrator will retaliate, (2) they will be blamed or accused of adultery, illegal sexual activity, or fraternization, (3) they will lose the respect of their peers and colleagues, (4) no action will be taken against the perpetrator, or (5) their careers will be adversely affected. According to the testimony of women veterans who have been victims of sexual assault while on active duty, these fears are not unfounded.

Thus, as the testimony at the Committee's June 30 and July 2 hearings clearly demonstrated, very few women veterans who are victims of in-service sexual violence are likely to be able to produce the substantiating evidence necessary to establish service connection, which in turn would be the basis for access to VA care. Also, even where documentation to support service connection exists, VA's adjudication process can take many months to produce a decision and time can be critical to the health and well-being of the woman veteran seeking assistance. According to VA, the average waiting time between June 1, 1991, and May 31, 1992, to decide a new claim for compensation was 158 days. Thus, women veterans would have to wait an average of 5 months after submitting a claim for compensation before they can make an appointment for needed treatment and counseling.

The Committee believes that a way must be provided to furnish expeditiously any counseling or medical care necessary for the treatment of sexual trauma to a woman veteran seeking VA help if it is reasonable to conclude that her needs are related to sexual violence she experienced while serving on active duty. In the Committee's view, the proposed new section 1720D(a) offers a responsible way to do so by making a women eligible for priority health care—not disability compensation—if a VA health professional designated by the Chief Medical Director concludes that she needs counseling or treatment for sexual trauma incurred during service. In order to receive compensation for conditions related to sexual trauma experience during active duty, a women veteran would have to go through the normal adjudication process.

With specific regard to the requirement that a health professional must make the determination that a women veteran is in need of counseling or treatment for the aftereffects of sexual trauma,

the Committee believes that the health professional designated by the Chief Medical Director should, where possible, have special training in the care and treatment of persons who have been victims of such violence.

Authority for contracting care for women veterans who have been victims of sexual trauma

Subsection (b) of new section 1720D of title 38, as would be added by section 101 of the Committee bill, would provide the Secretary with the authority, through December 31, 1994, to furnish counseling or treatment services for sexual trauma through contracts with non-VA providers and require the Secretary to provide to the Veterans' Affairs Committees of the Senate and House of Representatives by March 31, 1994, a report on the use of this authority.

The Committee is concerned that, when a woman servicemember approaches VA for counseling and treatment for the aftereffects of sexual violence, VA may not have the present capability to furnish quality care at all VA facilities. As discussed above, relatively few women veterans utilize VA for health-care services and the environment in some VA facilities may not be conducive to the treatment of women. Further, some women veterans may live long distances from VA facilities and it may not be practical for them to travel these distances as frequently as might be necessary. As the VA's Chief Medical Director testified at the July 2 hearing, VA is not currently in a position to treat appropriately all women veterans who have been victims of sexual trauma who might seek VA assistance. Additionally, as previously noted, Secretary Derwinski's July 28 letter indicated that he believes that a combination of direct VA care and contract care will be necessary in the foreseeable future because of the small numbers of women currently seeking treatment and the uneven distribution of women veterans in need of assistance, as well as the lack of research currently available that addresses women who were assaulted in the military. This provision in the Committee bill would furnish the necessary authority for the contract care portion.

Cost: CBO has informed the Committee that it is not possible to estimate the impact of the enactment of this bill on discretionary spending.

Information and Referrals for Women Veterans (Toll-Free Telephone Line)

Section 102 of the Committee bill, which is derived from section 3 of S. 2973 as introduced, would require VA to establish for women veterans a toll-free, 24-hour information and referral telephone line, which would be staffed by personnel trained to facilitate access to VA and community services relating to sexual trauma and which would protect the confidentiality of callers.

The Committee recognizes that women veterans do not use the VA health-care system in the same proportion as men veterans. Women constitute approximately 4.5 percent of the veteran population. Yet, according to the VA's Fiscal Year 1991 Annual Report, only 2.4 percent of discharges from VA medical centers in FY 1990 were women. Also, VA surveys of Vet Center visits conducted in 1986, 1989, and 1990 indicated that only approximately 2 percent of

the veterans seen there in each of those years were women veterans.

The Committee believes that VA must undertake significant outreach to women veterans if there is to be any change in this difference in utilization of VA services. Some efforts are already underway, although the Committee is not satisfied that such efforts are fully effective. In response to the Committee's questionnaire, 21 percent of Vet Centers and 9 percent of VA medical centers indicated that they have implemented special outreach efforts to ensure that women veterans who are victims of sexual trauma during active-duty service apply for any VA benefits or services that they may need as a result. In addition, 40 percent of Vet Centers and 14 percent of medical centers reported that they are planning special programs for this purpose. The outreach methods most frequently cited in these responses include items such as newsletters, health fairs, and media publicity.

At the Committee's July 2 hearing, Susan Mather, M.D., Assistant Chief Medical Director for Environmental Medicine and Public Health, described some VA outreach efforts that VA Central Office is supporting, such as making available pamphlets specifically targeted to women veterans about VA benefits, sponsoring a traveling benefits program, and encouraging local VA medical centers to hold recognition events honoring women veterans. In addition, Dr. Holsinger credited the Transition Assistance Program carried out in part by VA's Veterans Benefits Administration with significantly increasing the number of Persian Gulf women veterans seen by VA.

Despite these efforts, however, the Committee heard repeatedly at the June 30 hearing that many women veterans either were not aware that they were eligible for VA health-care benefits or that they were not comfortable seeking treatment at VA medical facilities because of the extent to which VA is oriented to male veterans. To address this situation, the Committee believes that further, special creative outreach approaches must be implemented to inform women veterans of their eligibility for VA health-care services and believes that initial information and referral through a toll-free telephone number is one such approach.

The Committee believes that the most effective way to implement such a service would be to establish a single office to receive such calls. Because it is often difficult for sexual trauma victims to discuss their experiences and because women veterans have shown reluctance to seek care and treatment from VA, the Committee believes that the persons answering these calls must receive training in issues pertaining to sexual violence and in listening and comforting skills. Community rape crisis centers often provide this training and the Committee urges VA to consult with these centers when planning its training programs.

In addition, telephone personnel should have a solid understanding of VA eligibility requirements and policies especially as they relate to a woman veteran seeking care for the aftereffects of sexual violence that occurred during active-duty service.

To be effective, the Committee believes that sufficient time must be provided to listen to a caller's situation, history, and requests for treatment or counseling. Because telephone personnel cannot

be expected to be familiar with the availability and range of services at all VA facilities and in all communities, the person taking the call should make arrangements to call the woman veteran back with pertinent information. When doing so, it is imperative that the veteran be assured that confidentiality will be maintained. The return telephone call, which the Committee believes should be made within 2 business days, should include, to the extent not provided in the initial contact, information such as (1) the closest VA facility at which the caller would be eligible for services, (2) a contact, such as a Women Veterans Coordinator, at the facility who could work directly with the caller in securing needed VA services, (3) the availability of a women veterans clinic or other special services for women veterans, and (4) the operating hours of the facility, outpatient clinic, or women's clinic. The Committee also believes that, in order to ensure that this service is truly effective, follow-up telephone contact should be made by VA approximately 1 to 2 weeks after a caller's initial call to determine if the woman veteran was able to obtain needed services or information.

The Committee notes that VA has experience in establishing and using toll-free services. For example, VA's Veterans Benefits Administration successfully uses toll-free hotlines at several regional offices to provide benefits information to veterans in the area. Both the Office of the Secretary and VA's Inspector General maintain free, confidential lines to report problems within the Department. Finally, it is the Committee's understanding that VA purchased a toll-free telephone system over a year ago with the capacity for 20 lines. This system, which was intended for a program targeted to veterans and families of the Persian Gulf War and cost VA approximately $40,000, has not been used.

Cost: According to CBO, the enactment of section 102 would entail no significant costs.

Report on need for care and services of veterans who have experienced sexual trauma

Section 103 of the Committee bill, which is derived from section 4 of S. 2973 as introduced, would require VA, in consultation with and with the assistance of the Department of Defense, to carry out and submit to Congress by December 31, 1993, a study on the extent of veterans' needs for treatment and counseling for the aftereffects of sexual trauma which occurred during active duty and the utilization of military and VA health-care services for servicemembers who were victims of sexual trauma.

The Committee believes that VA should have accurate data on the incidence of sexual violence within the military and the extent to which the victims of sexual violence have received treatment so that VA can plan effectively for services. Without this knowledge, the Committee is concerned that scarce financial and human resources may be used ineffectively when VA establishes programs to counsel and treat victims of sexual violence.

The Committee is concerned over the lack of data on how many women servicemembers have been victims of sexual assault while serving on active duty. The Committee is aware of only one DoD study, performed in 1988, which attempted to arrive at the number of women who have been victims of sexual violence while on active

duty. Despite that study's indication of a serious problem, the Committee is aware of no attempt to follow through with further study of the issue.

Nor does VA have data available to determine the extent to which women veterans need treatment or counseling for the aftereffects of sexual trauma which occurred while serving on active duty. Only 22 percent of VA medical centers and 37 percent of Vet Centers were able to furnish any information in response to the Committee's questionnaire. Secretary Derwinski, in his July 28 letter responding to the Committee's question about how frequently women veterans seek such assistance at VA facilities, stated that VA had no available data nor has VA conducted studies focused on women veterans who have been sexually abused or harassed during military service. Although VA is planning a study emphasizing the interpersonal military experiences of post-Vietnam-era women which will provide extensive data on subtle forms of sexual harassment and assault during military service, rape is not included.

During the course of the Committee's investigation and during the Committee's hearings, the issue of sexual violence against men in the military was raised. Some experts believe that the incidence of sexual assaults against male servicemembers is reported even less frequently than the incidence of sexual assaults of females. According to the Department of Justice's National Crime Survey released in 1991, of the 168,000 rapes which occur annually, 13,000 involve male victims.

Men who are sexually assaulted have problems similar to those of women who are victims of sexual violence. Men also experience feelings of shock, disbelief, embarrassment, depression, and fear. According to a study performed by Drs. Nicholas Groth and Ann Wolbert Burgess, reported in the American Journal of Psychiatry (July 1980), male rape victims feel pressure in not reporting rape for several reasons: (1) societal beliefs that a man is expected to defend himself against sexual assault, (2) the victim's sexuality may become suspect, and (3) telling about the incident is distressing. These feelings, although similar to those of women, may be more pronounced in men because of society's belief that males are strong and should be able to defend themselves. Attitudes such as these also prevent male victims from receiving medical treatment and psychological counseling.

The number of male veterans seeking treatment and counseling at VA medical centers or Vet Centers for the aftereffects of sexual violence has not been established. However, at the Committee's June 30 hearing Dr. Wolfe testified, "Post-traumatic stress and related psychological problems are not respectful of age or era of service, just as they are not of gender. * * * In terms of the sexual assault issue, we now see certain numbers of male veterans who have been victims of sexual assault during wartime service and their treatment is also considerably overlooked."

Because the Committee also is concerned about the needs of men who are victims of sexual violence while on active duty, this provision in the Committee bill requires that the same types of information collected regarding women be collected with respect to men who are members of the Armed Forces and men who are veterans.

Cost: According to CBO, the enactment of section 103 would entail no significant costs.

Report Relating to Services Available to Veterans Who Have Experienced Sexual Trauma

Section 104 of the Committee bill, which is derived from section 5 of S. 2973 as introduced, would require the Secretary of Veterans Affairs, by March 1, 1993, and by December 31 of each of calendar years 1993 through 1997, to provide the Committees on Veterans' Affairs of the Senate and House of Representatives with a comprehensive report on VA services for veterans who experienced sexual trauma, including (1) information on the medical care, counseling, outreach, and other services provided for these veterans, and the numbers of male and female counselors provided specialized training in the counseling of persons who have experienced sexual trauma; (2) an assessment of any quantitative or qualitative deficiencies in meeting veterans' needs in this area; and (3) plans to correct such deficiencies.

Women veterans at the Committee's June 30 hearing generally testified that, based on their personal experiences, VA was unable to meet their counseling and treatment needs for the aftereffects of sexual trauma. As discussed above, three of the four women veterans who testified received counseling or treatment or both in the private sector after attempting to obtain VA health care. The fourth veteran did not seek any treatment from VA. Likewise, VA officials testified that VA does not currently have the capability consistently, throughout its health-care system, to provide the services that are needed by veterans seeking counseling and treatment for the aftereffects of sexual trauma.

Dr. Susan Angell indicated, in response to a post-hearing question submitted by Senator Cranston, that the large numbers of male veterans found in the waiting areas of most VA facilities could be intimidating to women veterans who are victims of sexual assault. She also stated that, within the Vet Center program, extensive staff education on the assessment and treatment of sexual trauma is needed and that additional staff, particularly female staff, and related resources to provide such treatment and outreach would be required.

Dr. Freiberg stated that she believed that VA was working towards making Vet Center and medical center environments more conducive to women veterans and that one way of getting more women veterans involved would be to recruit more women veterans onto VA staffs. Dr. Wolfe testified that there are professionals in place, particularly on PTSD clinical treatment teams, who could readily provide treatment and counseling for sexual trauma if they have further extensive education and training. Joan Furey, RN, Associate Director at VA's National Center for PTSD division located in Menlo Park, California, and Marvin Abney, Ph.D., psychologist at the Audie Murphy VA Medical Center located in San Antonio, Texas, agreed with Dr. Wolfe's assessment. As previously indicated, Dr. Holsinger testified that VA was making headway in the area of treatment and counseling for the aftereffects of sexual trauma, but he also agreed that additional work was needed in this area.

The Committee is concerned that sufficient numbers of VA health professionals be provided with adequate and appropriate training to assist victims of sexual violence. Although the counseling of these victims is to some extent similar to that furnished to veterans suffering from PTSD related to combat, the needs of those experiencing combat-related PTSD and PTSD resulting from sexual trauma differ in significant ways. The Committee also is very concerned that many women veterans do not perceive VA as a place where they can receive quality care. As a result, the Committee believes that VA must make extensive efforts to train VA personnel and reach out to women veterans. The Committee expects the required report would provide comprehensive information regarding the status of current and planned programs and VA's effort to improve in these areas.

The Secretary, in his July 28 response to questions, said that the Veterans Health Administration is establishing a "Task Force on Treatment of Women Veterans Who Have Suffered Sexual Abuse" and that it was anticipated that this Task Force will meet in August 1992. Additionally, he stated that a September meeting is planned to establish a VA research agenda on women's health issues. The Committee is very interested in the results of these two meetings and encourages VA, in addition to submitting the report required by this section of the Committee bill, to report regularly on significant activity in the area of enhancing VA's ability to meet the needs of veterans who are victims of sexual assault.

Cost: According to CBO, the enactment of section 104 would entail no significant costs.

Provision of information on services to women who are separating from the armed forces

Section 105 of the Committee bill, which is derived from section 6 of S. 2973 as introduced, would require the Secretaries of Veterans Affairs and Defense jointly to ensure that all women being separated from active duty are given appropriate, in-person advice regarding (1) the availability of counseling, medical care, and other services and assistance from VA with respect to sexual trauma, and (2) the requirements for eligibility for or entitlement to, and the procedures for applying for, such counseling, medical care, and other services and assistance.

Women veterans at the Committee's June 30 and July 2 hearings repeatedly stated that they were unaware of the scope of their VA health-care benefits. Sylva Royer, a National Service Officer for the Disabled American Veterans, stated that many women veterans seem unaware that their military service has anything to do with VA. Ms. Danis indicated that she believed there needed to be a full-scale effort to educate women about VA benefits before leaving the service.

Ms. Richard testified that, when she sought information about PTSD from a VA benefits counselor, she was advised that care for PTSD was a condition that could be service-connected only for veterans who had been in combat and usually only for Vietnam veterans and so it was useless for her to file a claim. She went on to say that, since she had never heard anything different when she was in the Coast Guard, she "walked away from it [VA] feeling that it was

my problem." Ms. Richard suggested that women need to be educated about the benefits while they are still in the Armed Forces. "Had I been able to do that, I would have argued with the VA benefits counselor, I would have seen the supervisor, or I would have filed my claim much earlier. It would have saved me an enormous amount of interpersonal loss and economic loss," she said.

VA psychologists Drs. Freitag and Wolfe agreed with the other witnesses. Both indicated in their testimony that women veterans do not see VA as being there to serve them.

Before November 1990, no mechanism existed to ensure that servicemembers separating from active duty were fully briefed about VA benefits. In some areas, VA infrequently was able to provide benefits information directly to departing servicemembers, but in most areas of the country and overseas these sessions were nonexistent. For the most part, retirees rather than younger personnel separating from active duty were the recipients of these VA benefits briefings.

Historically, VA's largest outreach effort to educate departing servicemembers about VA benefits involved sending written descriptive material to the home address of record shown on each servicemember's discharge papers, with a similar follow-up packet mailed 6 months after the first. However, since VA must wait for the military to supply a mailing address, the initial material may not be sent for weeks or months after the servicemember separates from the service. Further, since the DoD-furnished address is not always current, the servicemember might not receive the information. Even if the servicemember receives the material, there is no assurance that it was read or understood.

To overcome these and other problems, Congress in 1989 and 1990 enacted Public Laws 100–237 and 101–510, which require the Department of Labor, DoD, and VA jointly to conduct the Transition Assistance Program (TAP) for individuals who are leaving active duty. TAP is intended to furnish separating servicemembers employment assistance, job training assistance, and other services, including counseling on VA benefits. According to VA, by the end of FY 1992, TAP workshops are expected to be available at 178 military installations. However, the primary focus of these programs is job assistance, and in a typical 3-day TAP workshop, only one-half of one day is devoted to VA benefits and services. Of this one-half day, an average of one-half hour may be spent on VA health-care benefits.

In addition to participating in TAP, VA recently expanded its military services program. Each regional office designated a military services coordinator. These coordinators provide briefings on VA benefits at regular pre-separation and retirement programs and function as liaisons with education program services, military medical facilities, physical evaluation boards, and family and personal service activities at military installations within their immediate jurisdiction.

VA reported that, from October 1, 1991, to June 30, 1992, military services coordinators participated in 4,429 briefing sessions attended by over 242,215 servicemembers. The coordinators also completed over 81,000 personal interviews during that period.

By September 30, 1992, VA expects, through TAP and otherwise, to contact in person approximately 88 percent of the servicemembers that DoD projects will be separated from the service during FY 1992.

The Committee believes that VA TAP sessions and VA-sponsored pre-separation and retirement briefings provide good opportunities for contacts with the vast majority of departing women servicemembers. The Committee believes that these would be appropriate occasions for providing in-person advice that the Committee bill would require regarding the availability of, and eligibility requirements for, VA counseling and other services and assistance with respect to sexual trauma.

In addition to providing information about VA benefits available for the aftereffects of sexual trauma, the Committee believes it would be helpful to include in such a program advice about the advantages of ensuring that pertinent information, including any incidents of sexual violence, be in the servicemember's record in case she needs it to obtain service-connected status in the future. Any advice on this point should make clear that the lack of recorded information would not preclude making a future claim, but that a claim likely would be more difficult to prove without such documentary evidence.

The Committee recognizes that the vast majority of women servicemembers who were sexually traumatized during service will not have any record of the incident or incidents in their personnel or medical records. The discharge medical examination would afford the departing servicemember an opportunity to include a reference to such incidents in the medical history taken as part of that examination, and the Committee intends that such advice be provided. However, not all women servicemembers—perhaps not even most—who were assaulted during service would take advantage of that opportunity even if properly advised regarding it, and there can be no assurance that such a reference would suffice to establish service-connection in all cases. Thus, the Committee believes that a woman servicemember should also be advised that it may be useful for her, before leaving service, to obtain statements from individuals who have knowledge that may be useful in substantiating any incidents of sexual violence or harassment that she suffered.

Cost: According to CBO, the enactment of section 105 would entail no significant costs.

Report relating to determinations of service connection for sexual trauma

Section 106 of the Committee bill, which is derived from section 7 of S. 2973 as introduced, would require VA, by December 31, 1992, to submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on (1) difficulties women veterans encounter in obtaining VA determinations that disabilities relating to sexual trauma that are the results of events that occurred during active duty are service connected and the extent to which VA fails to make determinations that such disabilities are service connected, and (2) what steps should be taken to respond in a fair manner to such difficulties and to eliminate such failures.

Women who have been victims of sexual violence that occurred during active-duty service may be eligible for VA compensation if they are found to have a physical or psychological disability stemming from the trauma. The procedure for filing a disability compensation claim for the aftereffects of sexual trauma is the same that would be followed for any other claim. The veteran must first file a claim at a VA regional office. If assistance is needed, a VA benefits counselor is available to help with this process. The regional office will request pertinent information that may support the claim, including the veteran's active-duty service records (including medical records) and any other medical records for the period prior to the veteran's discharge. The regional office also sets up an appointment for an examination by a VA physician who determines if there is any residual physical or psychological impairment that is the result of the illness or injury for which the veteran is seeking compensation. After all the evidence is received by the regional office, most cases are referred to a 3-member rating board to make a determination. If the determination is not favorable to the veteran, the veteran may appeal the decision.

Secretary Derwinski's July 28 response to pre-hearing questions confirmed the general understanding that disability compensation may be granted for compensable service-connected disabilities, either physical or psychological, which are the residuals of rape, other sexual assaults, or sexual harassment that occurred during military service. Testimony at the Committee's hearing showed that PTSD is one of the most common forms of residual psychological disabilities that result from sexual violence. To establish service-connection for PTSD, the claimant must show that he or she experienced an event in service that is outside the range of normal human experience and that would be markedly distressing to almost anyone, such as a serious threat to one's life. Rape and assault are both described in the most recent "Diagnostic and Statistical Manual of Mental Disorders, (Third Edition-Revised)"—the most authoritative text on psychiatric diagnoses—as significant stressors resulting in PTSD. Additionally, the instruction to VA rating boards specifically state that rape or assault is to be considered such an experience.

As previously discussed, sexual assault and rape is very often not reported by the victim nor do victims often seek medical care. As a result, there frequently is no recorded evidence in the woman's military records that the rape or assault occurred. This oversight creates a tremendous hurdle for women who are trying to obtain VA health care, disability compensation, or rehabilitative services for the aftereffects of sexual trauma that occurred while on active-duty service. VA field witnesses at the Committee's June 30 hearing were asked if, at the time of discharge from active duty, women servicemembers should be asked routinely if they were victims of sexual violence while on active duty. Dr. Wolfe responded that she would not encourage asking that question until proper safeguards and treatment resources are put in place. She also stated that she believed that many of the women who remained in the National Guard or Reserves might feel that an affirmative response to the question would jeopardize their careers. Dr. Angell expressed other concerns, noting that it was not likely that a woman would report

the incident at the time of discharge for fear of receiving a less desirable discharge or that making such a report would place her discharge in jeopardy. Dr. Angell also noted the concern that, if the women answered "no" to the question because of these or other concerns and she later decided to pursue a claim, there would be documentation in her record that she denied being a victim of sexual violence, making the process of succeeding with the claim even more difficult.

The Committee is very concerned that women veterans may not be receiving health-care compensation, and other assistance, to which they are entitled for disabilities incurred while on active duty. The Committee believes that if specific difficulties encountered by women veterans are determined and actions to remedy those difficulties are identified, then appropriate administrative and legislative steps can be taken to resolve those problems. The report required by section 106 of the Committee bill is intended to produce an in-depth examination of these issues by VA.

Cost: According to CBO, the enactment of section 106 would entail no significant costs.

TITLE II—HEALTH CARE FOR WOMEN VETERANS

Background

In 1948, with the enactment of the Women's Armed Services Integration Act, women were officially recognized as members of the military as auxiliaries to the service branches. By the 1970s the auxiliaries were finally abolished and women were fully integrated as members of the Armed Forces. However, women have served in, or in support of, the Armed Forces since the Revolutionary War. In this century, approximately 34,000 women served in World War I; 384,000, in World War II; 110,000, during the Korean War; and 261,000, in the Vietnam Era. Most recently, more than 33,000 women were deployed to the Persian Gulf and served in key combat-support positions. Women piloted and crewed planes and helicopters, drove trucks, ran prisoner-of-war facilities, served on support and repair ships in port of authority units and construction battalions, and performed myriad other jobs crucial to the success of Operations Desert Shield and Desert Storm.

Presently, some 378,550 women are members of the United States Armed Forces, constituting 11 percent of all active duty personnel. This represents a continuing and dramatic increase from the 1.6 percent figure of 1973 and the 8.5 percent representation in 1980. Thirteen percent of the personnel in the Ready Reserves are women.

Today there are 1.2 million women veterans in the United States, comprising 4.2 percent of total veteran population. It is expected that by the year 2000, the number of women veterans will increase to 1.3 million, representing 5.3 percent of all veterans.

As the Nation proceeds to downsize the military establishment, transition assistance programs have been established to ensure that veterans receive information about the benefits and services to which they may be entitled. Nevertheless, many women veterans remain unaware of the benefits and services available to them. Although VA has responded aggressively in many instances to

women veterans' needs in the past few years, it is the Committee's view that much remains to be done, particularly in the areas of the provision of health care services and VA's medical research agenda.

In 1982, the General Accounting Office (GAO) issued a report entitled "Actions Needed To Ensure That Female Veterans Have Equal Access to VA Benefits" (GAO/HRD-82-98, Sept. 1982). In 1990, Senator Cranston requested a follow-up GAO study on VA's progress in providing needed health care services to women veterans, and on any remaining barriers that restrict women veterans' access to health care. In January 1992, GAO reported that, although VA had made significant progress since 1982 toward ensuring that women veterans' access to health care is equal to that of men veterans, some problems remain. "(VA Health Care For Women: Despite Progress, Improvements Needed" (GAO/HRD-92-23, Jan. 1992)). Specifically, GAO focused on the following areas needing improvements:

Cancer Screening: GAO found that VA has not effectively implemented plans to ensure that, as part of their physical examinations, women veterans receive appropriate cancer screening. This is of great concern to the Committee in light of indications that women veterans experience an unusually high incidence of cancer. For example, VA's 1985 Survey of Female Veterans, conducted by Louis Harris and Associates, reported that nearly 9 percent of women veterans had cancer, almost double the 5 percent rate found in the total population of adult women. In that survey, the most common types of cancer were cancers of the reproductive system (uterine, ovarian, and cervical cancer—43 percent), followed by breast cancer (26 percent). In addition, a 1989 women veterans health inventory conducted by a gynecologist at the Bay Pines VA Medical Center found that nearly 50 percent of the 115 women included in the inventory had personal histories of cancer. Since the GAO report did not indicate what the criteria were for inclusion in the inventory, it is not possible to determine the significance of the data.

In its 1992 report, GAO states that, despite its having first identified problems relating to physical examinations in its 1982 report, more than 50 reviews, including those by VA's Systematic External Review Program, Medical District Initiated Peer Review Organization Inspector General (MEDIPRO), veterans service organizations, and internal quality assurance staff, have found that VA medical centers are not providing women patients with appropriate cancer screening tests as part of their complete physical examinations. For example, as described in GAO's 1992 report, MEDIPRO reviews in five districts found that from 20 to 86 percent of women patients did not receive breast and pelvic examinations, Pap tests, and mammograms when required. Moreover, GAO found that, despite these reviews, some VA medical centers continued to be non-compliant with VA's physical examination requirements. In addition, GAO found that some medical centers did not consistently monitor womens' care through their quality assurance programs.

Mammography: GAO found that VA medical centers are inadequately monitoring their mammography programs to ensure compliance with the American College of Radiology (ACR) quality

standards. The principal problem GAO found with VA medical center inspection of mammography equipment was with the frequency of the inspection. Fifteen of 19 medical centers (79 percent) did not meet at least one of the ACR recommended time periods for inspecting items of the mammographic equipment. For example, ACR requires that a radiologic technologist conduct a weekly check of the screens, which helps to ensure the quality of the images. Only eight medical centers (42 percent) reported doing such weekly checks. Two VA medical centers, Miami, FL, and Allen Park, MI, were not in compliance with five of the seven quality assurance standards.

GAO also reported that VA Central Office does not monitor VA medical centers' in-house mammography programs to ensure compliance with ACR quality standards. In fact, VA Central Office was unaware that 9 of the 19 medical centers had mammography equipment until GAO brought the fact to VA's attention in April 1991. In light of the suggestion of a high incidence of breast cancer in women veterans, the Committee is distressed by this finding. The Committee notes that the Secretary concurred with this finding and stated:

> VHA's Office of Environmental Medicine and Public Health will review plans for provisions of breast screening services submitted by VA medical centers in accordance with VHA Circular 10-01-101, dated September 12, 1991. * * * In coordination with its regional offices, VHA will also develop periodic monitoring of quality control and quality assurance aspect of mammography services and equipment.

Privacy: GAO found that VA medical centers have inadequate procedures to ensure that patient privacy limitations affecting women patients are identified and corrected during facility renovations. In its 1982 report, GAO recommended that VA revise its privacy standards and ensure that future construction or renovation projects correct privacy deficiencies that limit women veteran's access to facilities and treatment. VA subsequently surveyed its medical centers to identify those programs that could not accommodate women patients. On analyzing VA's surveys, GAO found them to be inadequate in two key respects.

First, VA provided little guidance on when a medical center should report that, it could not accommodate women patients. For example, GAO reported that, while the North Chicago VA Medical Center did not accept women in some of its psychiatric treatment programs, it did not report this problem in the VA survey. Second, although the survey responses identified the specific treatment programs—such as medicine, surgery, or psychiatry—that could not accommodate women patients, VA medical centers did not give an adequate description of the specific deficiencies that prevented such accommodation, making it difficult for GAO to determine the status of corrective actions.

Because of deficiencies in the surveys, GAO found that VA has not adequately followed up to determine whether corrective actions have been completed. VA identified, at GAO's request, all major renovation projects at the 28 medical centers reporting that women

could not be accommodated in one or more programs. From the information VA gathered, however, neither VA nor GAO could determine whether renovations at many of the medical centers had corrected the privacy deficiencies that had limited women patients' access to treatment programs in 1982 because neither the original survey nor the summary of renovation projects gave details of the specific deficiencies limiting women veterans' access.

The Committee notes that the Secretary concurred with the GAO finding regarding privacy and also stated in his April 3, 1992, response to a January 10, 1992, letter from Senator Cranston urging expeditious actions:

> I am pleased to let you know that the Veterans Health Administration (VHA) staff will have accomplished the tasks related to assuring adequate privacy in VA facilities prior to November 1992. The Chief Medical Director informs me that special considerations for female privacy have already been incorporated into the methodologies used in prioritizing the Nonrecurring Maintenance and Minor Construction projects. The subcategory for female veterans was approved at VHA's Regional Construction Managers Meeting, March 16–20.

Committee Hearings

At the Committee's June 19 and July 2 hearings, women veterans, representatives of veterans service organizations, Women Veterans Coordinators, a member of the VA Advisory Committee on Women Veterans, VA officials, representative of professional nursing organizations, and GAO testified concerning the following matters pertaining to women veterans: (1) VA's progress in improving health care services for women veterans; (2) problems associated with women veterans obtaining access to health care services and the quality of those services; (3) health care and health care research needs of women veterans; and (4) actions that can be taken by the Congress and VA to ensure that women veterans research needs are addressed and that they receive access to health care services.

With respect to the progress that VA has made in improving health care services for women veterans, David P. Baine, GAO's Director of Federal Health Care Delivery Issues, Human Resources Division, testified at the Committee's June 19 hearing that, while VA has made significant progress in the last ten years toward ensuring that women veterans' access to health care is equal to that of male veterans, three problems remain, as discussed in the previous Background section.

Witnesses who use VA health care services testified concerning issues of equity in health care services for women veterans and remaining barriers within VA Medical Centers (VAMC) that impede access to health care services. Linda S. Schwartz, R.N., M.S.N., Chairperson, Vietnam Veterans of America (VVA) National Committee on Women Veterans, testified, "While there has been great attention paid to the expanded roles of women in the military during the recent Operation Desert Storm, we see that such attention has not translated into provisions for care of them as veter-

ans." She testified further in support of routine diagnostic tests for cancer in women veterans and emphasized the need for competent health care providers with this anecdote:

> On my most recent visit for a gynecological exam at the VA, I overheard the resident physician outside my door ask the clinic aide how to do a Pap smear. He actually said he was a surgeon and didn't know how to do this procedure.

Ginger Ruckman, another woman veteran who is a recipient of VA health care, testified concerning problems she had encountered with a breast examination at the Erie and Buffalo VA Medical Centers in late 1991. Ms. Ruckman, who has a family history of cancer, was notified that her breast examination at Erie "didn't look good." With the intervention of the Women Veterans Coordinator, she was able to obtain a mammogram at the Buffalo VAMC in November 1991. Nevertheless, she was never fully informed regarding the examination results.

It was only the coincidence of her Committee testimony in June 1992 that led to her learning the results of her examination. She testified that, in preparing her testimony for the Committee hearing, she reviewed her VA medical file to verify dates and discovered information she should have been given six months earlier:

> When I pulled the dates out of my file to check the dates * * * my medical record states that I have multi-small nodular densities with small cysts and manifestation of fibrotic cyst disease. They never told me. We're talking seven months. Seven months, and they told me seven months ago, nothing was wrong. * * * It's wrong what they've done.

Ms. Ruckman told the Committee that her

> personal fear is that the next time that I'm seen in a VA medical facility, I'll find another doctor who is incompetent or didn't care enough that I wasn't important enough as a human being to advise me of what was wrong. It may cost me my life. If your [Committee] hadn't notified me to check the dates this paper would have never been brought to my attention.

Lieutenant Colonel Beverly A. Albaugh (Ret.), a registered nurse, is another woman veteran who receives health care services from a VA medical center. Responding to the Committee's inquiries about the quality of health care services rendered and the barriers to that care, Lt. Col. Albaugh testified that it took VA nearly five months to establish temporary medical records after hers were lost and that it took an inordinate amount of time to post examination results to her records. With respect to contracted procedures—such as mammography—she testified that it can take as long as six months to post results to her records. "How," she asked, "can I possibly receive quality medical care when my records did not contain appropriate information necessary for my health care?"

Lt. Col. Albaugh also noted that many of the problems that she has encountered within the system affect most veterans receiving

care at the VAMC. She "strongly" feels that many of the barriers to accessing health care occur because she is a female veteran and "this is a way of discouraging me from seeking care." She reported that the VA medical center does not have handouts or brochures describing available services and does not provide any mechanism for identifying the women veteran population receiving care.

Despite VA's efforts to use Women Veterans Coordinators to advise women veterans on their entitlements and to facilitate their care, several witnesses testified that this outreach effort is not effective in many VA facilities. These witnesses, including the Women Veterans Coordinator at the Washington, D.C., VAMC, as well as representatives of the American Nurses Association, VA's Advisory Committee on Women Veterans, and the Vietnam Veterans of America testified that (a) the Women Veterans Coordinator, which is typically an "additional duty," should be a funded position; (b) Women Veterans Coordinators need adequate office space and clerical assistance; (c) Women Veterans Coordinators should have direct access to VAMC department chiefs in order to fulfill their role in facilitating services to women veterans; and (d) full-time Women Veterans Coordinators should be appointed in each of VHA's four Regional Offices.

Linda Schwartz of VVA put the matter succinctly:

> The appointment of Women Veterans Coordinators with little or no time allocated for this responsibility is a cruel hoax both to those assigned the duty and those they are assigned to serve. The efforts of these Coordinators reflect individual accomplishments rather than a system-wide level of service or commitment.

The Committee also heard testimony from witnesses on the health care research needs of women veterans. Witnesses representing the American Nurses Association and Vietnam Veterans of America testified that the research provisions in S. 2028 were both timely and appropriate, pointing out that there is a lack of scientific data on women veterans due to the few clinical studies on that group. These witnesses agreed that a comprehensive study of the health care problems of women veterans is not only a necessity in accurately assessing the health status of this population, but a realistic strategy in planning and implementing health care policies that will ensure proper utilization of resources while promoting quality health care.

With the exception of a few provisions, the witnesses were supportive of S. 2028. One major provision that the veterans service organizations objected to was the original eligibility criteria as set forth in S. 2028. For example, the Disabled American Veterans testified that S. 2028 created an eligibility criteria for furnishing well-women care services to women veterans that is broader in scope than that currently provided to similarly situated male veterans for their general health care needs. This issue has been addressed and changes have been made, in title II of the Committee bill, to conform to current eligibility standards for all veterans.

Committee Bill

Well-women care services

Section 201 of the Committee bill would amend section 1701 of title 38 to add the term "well-women care services" to the definition of "medical care" so as to authorize VA to furnish health-care counseling and services with respect to physical and psychological conditions of women veterans even though such counseling and services may not be considered to be the care or treatment of a disability nor preventive health-care services. Well-women care services would include counseling and services related to Papanicolaou tests (pap smears), breast examinations and mammography, general reproductive health care, the management of infertility, menopause, and the effects of sexual violence. The term would exclude pregnancy care (except in those cases in which the risks of complications of pregnancy or pregnancy outcome are increased secondary to a service-connected condition) and abortion.

The Committee bill would also amend section 1703 of title 38, which authorizes VA to contract for hospital care and medical services in non-Department facilities, to add a new subsection authorizing a 2-year discretionary authority to contract with non-VA entities for the furnishing of well-women care services on an outpatient basis.

The Committee believes that these additions would provide eligible women veterans with counseling and services necessary to address an array of women veterans' health-care problems, particularly the apparently disproportionate incidence of reproductive cancers among women veterans. The Committee expects that providing the explicit authority to furnish cancer-screening procedures will lead VA to redouble its efforts in this critical area. The Committee believes that these services are not only vital to women veterans, but they are also in line with VA's goal to emphasize preventive health-care services within the system.

The Committee also believes that well-women care services must be established to meet the health care needs of the growing group of older women veterans. Accordingly, the definition of "well-women care services" includes services to meet the physiological changes which accompany menopause.

Finally, the Committee believes it is critical to quality patient care that well-women care services be provided by qualified personnel. It is the Committee's understanding that, as of March 1992, VA employed a total of two full-time board-certified gynecologists and 27 part-time gynecologists (of whom 19 were board certified). In light of these statistics, the Committee intends that VA establish contract services with community-based clinics and private practitioners if there is not a sufficient number of women veterans to justify the service within a VA medical center or when a qualified health-care provider is not available.

In order to monitor VA's progress in this area, section 201 of the Committee bill would require VA to submit an annual report providing (a) information on the extent of well-women health-care services provided by VA personnel or under sharing or contract agreements, (b) the numbers of individuals and the FTEE supporting such services, (c) an assessment of any difficulties in furnishing

such services and the actions and plans taken to resolve such difficulties, and (d) a description of VA's efforts to foster and encourage the expansion of research involving health-care concerns of women veterans.

Cost: Although CBO stated that it was unable to estimate the costs resulting from the enactment of section 201 of the Committee bill, it does estimate that if 10 percent of the 1.2 million current women veterans seek VA gynecological services, and if the average cost of a yearly visit is $90, then the annual cost for this provision could be $11 million.

Expansion of research relating to women veterans

Section 202 of the Committee bill would expand VA's current medical research program, under section 7303 of title 38, so as to require the Secretary to encourage and advance research involving the following matters as they relate to the health-care concerns of women veterans: breast cancer, gynecological and hormonal matters, cancer of the organs of the reproductive system, Alzheimer's Disease, osteoporosis, post-traumatic stress disorder, substance abuse, and sexual violence. In so doing, the Secretary would be required to consult with the Director of Nursing Service, the Central Office officials assigned responsibilities for women's programs and the operation of VA's research program, the Advisory Committee on Women Veterans, and relevant task forces within the Department, such as the Task Force on Treatment of Women Who Suffer Sexual Abuse. For these research areas, section 202 would authorize the appropriation of $1.5 million, $2 million, and $2.5 million for fiscal years 1993 through 1995. Funds appropriated to VA would be in addition to other funds appropriated or otherwise made available to VA for research.

While VA has long been a leader in health-care research, for too long women have been excluded from its research studies. Although VA has required, since 1983, that all studies of veterans conducted or contracted by VA include women veterans, women veterans continue to be underrepresented. And although VA now requires all applicants for clinical research support to consider the inclusion of women and minorities in their research proposals (VHA Circular 10-91-057), it appears that a small proportion of the $227 million appropriated for VA research in fiscal year 1992 went directly to issues which concern women veterans. Indeed, in late 1991, VA could identify only about $1.7 million that was directed at research specifically involving women, and that figure was derived from a single researcher who, out of personal interest, kept track of that funding. Because of its view of the importance of the health-care needs of women veterans, the Committee does not believe that is sufficient funding, nor does it believe that VA should be without accurate figures on this important work.

With respect to specific areas requiring study, the Committee has learned of gender discrepancies involving the diagnosis of psychosis. For example, in 1990, 14.8 percent of women's admissions to VA hospitals were for a diagnosis of psychotic illness, while only 8.9 percent of men's hospitalizations were for the same reason. Furthermore, a greater proportion of these illnesses were related to alcohol among the VA-hospitalized male population suffering from

psychotic illness than among the women, thus increasing the disparity between men and women with respect to non-alcohol related psychotic illness. Whether or not the actual psychiatric states of the men and women veterans involved justify this disparity is unknown. Nevertheless, the significant difference leads the Committee to conclude that further evaluation is merited. Accordingly, section 202 would require GAO to study the significant differences in proportionate psychotic diagnoses among male and female admissions to VA health-care facilities, including exploration of differences in symptom prevalence, gender-related diagnostic difficulties, and gender-associated use of VA health-care services.

Cost: According to CBO, the enactment of section 202 would entail costs of $1.5 million, $2 million, and $2.5 million for fiscal years 1993 through 1995.

Research of the Department of Veterans Affairs relating to womens' health-care issues

Section 203 of the Committee bill would amend section 7303 so as to require the Secretary, to the extent the Secretary determines that the quantity and nature of information available to VA personnel relating to the health-care needs of women veterans is inadequate for those personnel to carry out research on women veterans, to take action to ensure that the Department's medical research gives consideration to issues relating to the health of the general population of adult women in the United States. In doing so, the Secretary would be required to give particular consideration to health conditions affecting greater numbers of women which may also be prevalent to a significant degree among women veterans, or which may relate to women veterans differently. Section 203 would also require the Secretary, to the maximum extent practicable, to take appropriate actions to ensure that VA researchers are informed of the existence and progress of other research relating to women veterans conducted by or under the jurisdiction of the Secretary.

The Committee is aware of the increased federal government emphasis on including women in clinical research trials. For example, the National Institutes of Health (NIH) has made significant progress in expanding its women's health research efforts including, in September 1990, the establishment of an Office of Research on Women's Health. More recently, NIH launched the Women's Health Initiative, a large clinical project to study chronic diseases such as cancer, cardiovascular disease, and osteoporosis and their prevention in at least 140,000 women. This project is expected to take 10 years to complete. The Committee recognizes the importance of NIH's work, and believes NIH can provide VA with vital information concerning the general population of women, information which may have significance to the population of women veterans. The Committee believes it is important for VA researchers to be informed concerning both NIH findings and other researchers' findings as they relate to women's health.

Cost: CBO stated that it is unable to estimate the cost of section 203 of the Committee bill because it does not know how VA would implement this provision.

Population study of the need of women veterans for health-care services

Section 204 of the Committee bill would require the Secretary to conduct an ongoing population study of women veterans' health-care-services needs, requesting the advice of the VA Advisory Committee on Women Veterans and the Department of Defense Advisory Committee on Women in the Services, and, to the extent feasible, using data available from the United States Census and data obtained in carrying out the study conducted under section 102 of Public Law 98-160, the "National Vietnam Veterans Readjustment Study." In carrying out the population study, the Secretary is to examine the medical, biopsychosocial, and demographic histories of a representative sample of women veterans and women members of the Armed Forces, including women who represent a range of ages, ethnic, social, and economic backgrounds, of officer and enlisted service, and service in the various branches of the Armed Forces. The Secretary would be required to submit reports to the Committees on Veterans' Affairs of the Senate and House of Representatives on the population study. The Committee bill authorizes the appropriation of $1.5 million to the Department to carry out the study.

The Committee is deeply concerned with the incidence of reproductive cancers suffered by women veterans. Although abnormal statistics were found in the 1985 Harris Population Survey and the 1989 Bay Pines health inventory, until recently no follow-up studies were undertaken by VA to validate or investigate the incidence of cancer among women veterans. The Committee notes with approval the Secretary's recent announcement to begin a study of this important issue.

Therefore, the Committee believes that VA should direct special attention and effort at performing this population study in order to define the social and health conditions of women veterans. Such a study, in the Committee's view, would be most useful in enabling the VA health care system to meet the demands of women veterans by targeting and designing relevant strategies and research initiatives as well as improving delivery of health care by better determining the needs of this population. The Committee has received very favorable comments regarding the population study from veterans service organizations, women veterans, and professional nursing organizations.

Cost: CBO provided no specific estimate for section 204.

Report on research relating to women veterans

Section 205 of the Committee bill would require the Secretary to submit to the Committees on Veterans' Affairs of the Senate and House of Representatives, not later than July 1 of each of the next four years, a report which includes (a) a description of the status of any research relating to women veterans being carried out by or under the jurisdiction of the Secretary and (b) the recommendations of the Secretary as to future research relating to women veterans.

At the Committee's July 2 hearing, Dr. Holsinger testified that, in fiscal year 1991, VA's medical research program sponsored

nearly a hundred investigations fundamentally oriented to issues on women's health ranging from basic research in female hormones to osteoporosis. VA has difficulty, however, in retrieving information concerning the status or findings of these studies or previous studies on women veterans. Consequently, the Committee believes there is a need to have an organized compilation and description of any VA research relating to women veterans.

Prior to the commencement of the Committee's hearings, VA did not have within the Department a formal research agenda-setting process to identify high priority research issues for women. The Committee notes with approval that VA intends to establish such a process in 1992.

Cost: CBO stated that it is unable to estimate the cost of section 205 of the Committee bill because it does not know how VA would implement this provision.

Support for women veterans coordinators

Section 206 of the Committee bill would require the Secretary to provide funding to enable Women Veterans Coordinators at each VA medical center to have adequate clerical and communications support and ensure that each Women Veterans Coordinator has direct access to the Director or the Chief of Staff of the medical center where the Women Veteran Coordinator is assigned.

At the Committee's June 19 field hearing, Marcia Four, R.N., a woman veteran, summarized the importance and the needs of the Women Veterans Coordinators:

> Some coordinators have expressed concern and stated that this very part-time position often takes a back seat to other duties and doesn't permit them adequate time to provide for the needs of their patients. In some facilities they exist with little access to administrators in trying to solve identified problems or needs of the women veteran. These coordinators are an essential ingredient to the success of care given through Women Veteran Clinics in the VA.

The Committee agrees that this position is a vital link in reaching and assisting the women veterans population. The Committee is therefore concerned by the difficulties women veterans may confront when accessing VA health care services. In June and July, 1992, members of the Committee staff called over 20 VA medical centers and asked the operator to connect them with the Women Veterans Coordinator (WVC). Not one of these calls went through without a problem. Common VAMC operator responses included not knowing who the WVC was; noting that the WVC was on leave or otherwise unavailable and that there was no one designated to carry out her duties in her absence; responding that the women's coordinating work was done by volunteers who were not there at the time; suggesting that the personnel department handles that issue; and indicating that there was no WVC designated, followed by a referral of the call to the Patient Representative, who also often was not available.

The Committee staff members reported that, during these calls they were frequently put on hold for extended periods or were

transferred a number of times to incorrect facility telephone extensions. Such delays and lack of attention may have very serious consequences when a woman veteran calls for assistance. The Committee staff knew and gave the VA title of the position and, knowing that such a position existed—at least nominally—at each facility, were able to persist in their demands to be contacted with the WVC. A woman veteran with a health problem who calls a VA facility and says she'd like help faces a much greater obstacle to getting through to a WVC and the special assistance WVCs are supposed to provide.

Cost: CBO stated that it is unable to estimate the cost of Section 206 because it does not know how VA would implement this provision.

Regional women veterans coordinators

Section 207 of the Committee bill would require the Secretary to appoint a full-time Regional Women Veterans Coordinator at each Veterans Health Administration regional office to coordinate the training of Women Veterans Coordinators based at health-care facilities within the region and provide technical support and guidance with respect to outreach to women veterans.

At the Committee's July 2 hearing, VVA testified that it believes that a Women Veterans Coordinator should be appointed in each VHA regional office on a full-time or part-time basis not to exceed two years. The American Nurses Association also supported the concept of and need for Regional Women Veterans Coordinators.

In answering post-hearing Committee questions on supporting the position of Regional Women Veterans Coordinators, James W. Holsinger, Jr., M.D., VA's Chief Medical Director stated:

> The Veterans Health Administration has four Regional Offices, one of which has a Women Veterans Coordinator at present. The feasibility of appointing coordinators at the other three is being examined. We do not favor limiting the duties of any coordinator to outreach. Nor do we think that the need for coordinators will be limited to two years.

The Committee believes that Regional Women Veterans Coordinators are necessary within VA to provide a more formal and structured advise process for Women Veterans Coordinators in their assignments as advocates for women veterans. The Committee also intends that a Regional Women Veterans Coordinator would conduct formalized outreach and educational initiatives for Women Veterans Coordinators at various VA medical centers.

Cost: CBO stated that it is unable to estimate the cost of section 207 because it does not know how VA would implement this provision.

Funding for certain activities of the Advisory Committee on Women Veterans

Section 208 of the Committee bill would require the Secretary to make available travel funds to support reasonable site visits to VA medical facilities by members of the Advisory Committee on Women Veterans regarding women veterans' health-care needs and services as well as meetings of the Committee.

At the Committee's July 2 hearing, Shirley Menard, Chairperson of VA's Advisory Committee on Women Veterans, testified that, although progress has been made by VA in addressing women veterans issues, the remaining problem is that the progress is not enough. Ms. Menard attributed this problem to the fact that funding is limited. She stated:

> For example, the Advisory Committee which I serve on has very limited funds. If we are truly to do our job as an Advisory Committee, then we must be able to go out and visit VA hospitals and sites, not necessarily at our own expense each time. * * * If I'm not in the facility, if the [Advisory] Committee is not in the facility, then there appears to be some idea that the [Advisory] Committee really isn't interested or VA isn't interested in looking at women's issues. So more money, more funding for the [Advisory] Committee so that they could hold more than one or two meetings a year and so they could make site visits.

The Committee believes that the Advisory Committee is an integral part of VA's ability to respond to the issues and problems concerning women veterans. The Committee notes the significant contributions of the volunteer members of the Advisory Committee. Their expertise is indispensable in assessing equity and quality of VA services for women veterans.

Cost: CBO stated that it is unable to estimate the cost of section 208 because it does not know how VA would implement this provision.

Cost Estimate

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (CBO), notes that it is not possible to estimate the impact of the enactment of this bill on discretionary spending but that there will be no impact on direct spending or receipts. The cost estimate provided by CBO follows:

U.S. Congress,
Congressional Budget Office,
Washington, DC September 10, 1992.

Hon. Alan Cranston,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: At your request, the Congressional Budget Office (CBO) has reviewed S. 2973, the Women Veterans' Sexual Trauma Services Act, as ordered reported by the Senate Committee on Veterans' Affairs on August 7, 1992. This bill would provide care and services to female veterans who experienced sexual trauma while on active duty. It would also require a study of the needs of such veterans. CBO cannot predict the response of female veterans to the care and services offered by this bill and so cannot estimate with any certainty the total cost of the bill. Enactment of S. 2973 would not affect direct spending and receipts and thus would not be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

The following is a description and analysis of provisions of the bill that could have a budgetary impact. All such provisions would have to be funded in appropriation bills.

TITLE I—COUNSELING AND TREATMENT FOR SEXUAL TRAUMA

Currently, female veterans who were the victims of sexual assault while in the armed services are eligible for counseling only if they are certified as victims of Post-Traumatic Stress Disorder (PTSD). Few of these female veterans have received counseling under the current eligibility requirements. S. 2973 would extend counseling to any female veteran who experienced sexual trauma during military service, and who is certified by a Department of Veterans Affairs (VA) health professional to be in need of counseling or treatment for such trauma, even though the trauma has not been determined to be service connected.

The number of women veterans who will seek counseling as a result of this provision is difficult to predict. In 1988, the Department of Defense (DoD) conducted a survey of sexually-abused women. Approximately five percent of the active-duty female respondents reported attempted rape or sexual assault within the last 12 months. If the results of the DoD survey are accurate, at least 60,000 of the current 1.2 million female veterans could be eligible for VA counseling under this bill. CBO cannot estimate with any certainty the number of eligible women who would use counseling to the extent that PTSD patients use counseling (an average of 6.5 sessions, at an average cost of $84 per session), this provision could cost nearly $7 million.

TITLE II—WELL-WOMAN CARE

Currently, only a few VA medical centers have gynecologists on staff and are able to offer in-house gynecological care to female veterans. Female veterans can be provided inpatient gynecological care under contract if they are generally eligible for inpatient care from VA. Outpatient gynecological care however, can only be provided under contract to the extent that it would be related to an inpatient stay or would make an inpatient stay unnecessary. Title II of S. 2973 would authorize VA to provide certain gynecological and well-care services to female veterans on a contract basis without the current restrictions.

Again, CBO cannot estimate with any certainty the number of female veterans who would use this authority. The cost of a routine gynecological exam averages about $90. If, for example, 10 percent of female veterans obtain an exam each year at VA expense, the cost of this provision could be about $11 million annually.

Title II would also authorize the appropriation of $6 million for 1993–1995 for research on health issues related to female veterans. If appropriated, these funds would be expected to outlay over a five-year period.

If you would like further details on this estimate, we will be pleased to provide them. The CBO staff contact is K.W. Shepherd, who can be reached at 226–2840.

Sincerely,

ROBERT D. REISCHAUER,
Director.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any significant regulation of individual or business or result in any significant regulation on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at an August 7, 1992, meeting. On that date, the Committee voted by voice vote to report S. 2973 favorably to the Senate with an amendment in the nature of a substitute.

AGENCY REPORTS

On August 5, 1992, the Committee Chairman asked the Secretary of Veterans Affairs for a report setting forth the Department's views on S. 2973. As of the date of the filing of this report, the response to that request had not been received.

On January 29, 1992, the Chairman asked the Secretary for a report setting forth the Department's views on S. 2028. The Secretary's April 9, 1992, response follows:

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC April 9, 1992.

Hon. ALAN CRANSTON,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This will respond to your request for a report on S. 2028, 102nd Congress, 1st Session a bill "[t]o amend title 38, United States Code to improve and expand health care and health-care related services furnished to women veterans by the Department of Veterans Affairs."

S. 2028 would amend chapter 17 of title 38, United States Code by adding section 1771 that would require the Secretary to provide "well-women care" services to any women veteran who has a service connected disability, or to any woman who is eligible for hospital care under 38 U.S.C. § 1771 and who also meets certain income requirements. "Well-woman care services" is defined as counseling and services relating to: papanicolaou tests (pap smear); breast examinations and mammography; the number and spacing of children; contraception; general reproductive health care; the manage-

ment of infertility; and adoption. The proposed legislation explicitly excludes pregnancy care (including prenatal and delivery care) and abortion from this definition.

S. 2028 would expand the Department's medical research program. Specifically, the bill directs the Secretary to initiate research and expand ongoing research into the health consequences for woman veterans of the following matters: breast cancer; gynecological and hormonal conditions, including pregnancy; cancer of the organs of the reproductive system; alzheimer's disease; osteoporosis; and post traumatic stress disorder.

The bill directs the Secretary to carry out a study to determine the frequency of the diagnosis of mental illness as the basis for the admittance of women to VA facilities, to make the same determination for men, and to explain the difference in such frequencies, if any.

S. 2028 further requires the Secretary to conduct a study, commencing not later than December 31, 1993, to determine the health-care needs of women veterans as of that date, and for a ten-year period beginning on that date. The sample for this study shall include both women veterans and women serving on active duty in the armed forces who represent the full range of ages, and ethnic, social, economic and service-related backgrounds of such women. Prior to conducting this study the Secretary shall request the advice of the Advisory Committee on Women Veterans, and in consultation with the Secretary of Defense, the Advisory Committee on Women in the Services.

Finally, S. 2028 would amend chapter 73 of title 38, United States Code by adding a new section 7303A. This new section would require the Secretary to ensure to the maximum extent practicable that research carried out pursuant to section 7303 reflects matters that are significant to the general population of women in the United States and that populations analyzed are representative of the incidence of the condition or illness in the general population of women in the United States. This new section would further require the Secretary to ensure, to the maximum extent practicable, that personnel conducting research under section 7303 are aware of the existence and progress of VA research relating to women veterans.

We favor the general purpose of the bill, to improve the quality and enhance the availability of medical care for women veterans. However, we believe that S. 2028 would: create inequitable eligibility provisions based on gender, establish health care services in the VA system that are not "needed medical care," and create unnecessary authorizations because many provisions duplicate existing regulations in both the medical care and research programs. We also note that the research provisions of the bill could be counterproductive. For these reasons, fully explained below, the Department opposes enactment of S. 2028.

Section 2 requires the Secretary to furnish "well-women care services" to women veterans who meet the eligibility requirements of that section. This section further requires the Secretary to provide "well-women care" to any woman veteran who has a service-connected disability or to any woman who is eligible for hospital care under 38 U.S.C. § 1710 and whose annual income does not

exceed the maximum rate of pension under 38 U.S.C. 1521. In comparison, 38 U.S.C. § 1712(a) requires the Secretary to furnish medical services on an outpatient basis to: any veteran for a service-connected disability; for any disability of a veteran who has a service-connected disability rated at 50 percent or more; or to any veteran for a disability for which the veteran is in receipt of compensation under 38 U.S.C. § 1151.

Therefore, unlike VA's general outpatient care statute, S. 2028 requires the furnishings of services to any woman veteran for any disability provided that she has a service-connected disability. Moreover, under S. 2028 there is no minimum disability rating, rather a woman merely needs to show that she has a service-connected disability. Consequently, to the extent that "well-women care" would be furnished on an outpatient basis S. 2028 results in inequitable treatment of male veterans. Such disparate eligibility based strictly on gender may also raise constitutional equal protection problems.

We oppose the inclusion of counseling and services relating to the number of spacing of children, contraception, infertility management, and adoption in the definition of "well women-care" services because these services do not represent needed medical care. This has long been VA's position. The provision of infertility services remains a controversial issue for many elements in American society. We strongly oppose placing VA in the midst of that controversy. Adoption also does not represent medical care, and would place VA in the position of making ethical determinations as to who should and should not be a parent.

Further, the scope of some "well-women care" services as defined in the bill duplicates programs already provided by VA. Papanicolaou tests (Pap smears), breast examinations, and mammography services are currently provided under the Department's preventive health care program.

Finally, we note a potential ambiguity in the definition of "well-women care" services in section 2(a) of the bill. That section defines "well-women care" services to include "counseling and services relating to * * * [t]he number and spacing of children[,] * * * contraception[,] * * * [and] general reproductive health care * * *." Although it does specifically exclude pregnancy care and abortion from the definition, we are concerned that the section could be construed to require abortion counseling and referrals, notwithstanding the explicit exclusion of abortions. *F. Rust* v. *Sullivan,* 111 S.Ct. 1759 (1991) (dispute whether prohibition on funding programs in which abortion was a method of family planning extended to prohibition of abortion counseling and referrals).

Section 2(c) requires the Secretary to provide "well-women care" through Department facilities and personnel unless it is not feasible to do so, in which case the Secretary may provide such services by contract. This subsection also provides that the Secretary shall prescribe the qualifications for personnel providing "well-women care." This subsection is unnecessary inasmuch as title 38, United States Code, already contains similar provisions at sections 7301, 7409, 7402 and 8153.

Specifically, 38 U.S.C. § 7301 requires Veterans Health Administration (VHA) to provide a complete medical and hospital service.

However, where the requirements of sections 7409 or 8153 are satisfied the Secretary may enter into contracts for scarce medical specialist services or specialized medical resources respectively. The requirements of these sections for contracting out are thus substantially the same as those contained in section 2(c)(2).

Likewise, sections 7402, 7406, either delineate, or direct the Secretary to prescribe, the qualifications for VA health-card professionals. In addition, VHA privileging ensures that employees who are independent health-care practitioners are fully qualified to provide the medical services outline in section 2. The procedures for determining the qualifications of individuals providing services under contract are contained in current Federal Acquisition Regulations. Thus, section 2(c)(3) is superfluous. Accordingly, we oppose this section.

Section 2(d) authorizes the Secretary to take such action as he considers appropriate to encourage employment and retention of gynecologists and other health-care professionals who are qualified to furnish such services. The Secretary already has authority to provide geographic and scarce specialty special pay under 38 U.S.C. §§ 7431–7434 for such physicians. Hence, we oppose section 2(d).

Section 3 of the bill would create a special research initiative for investigation of a defined list of diseases in women. VHA has responded to concerns raised by the Women Veterans Advisory Committee concerning the VA Research Program. During 1991, the Chief Medical Director issued clear policy guidance to assure that the incidence of diseases in women is considered as a factor in the development of all VA research proposals. VHA Circular 10–91–56. In the near future, VA and the Department of Defense are planning to conduct a broad epidemiological study of the incidence of breast cancer among women veterans. We expect that the study will also provide valuable information about other women's health diseases.

Section 3 also includes an authorization of funding that could prove detrimental to the purposes of the Act. For example, in FY 1990 VA spent over $1.0 million of its appropriation on research related to women's health problems, and VA researchers received an additional $5.0 million from non-VA sources for similar research. As a result of the emphasis that we are providing, VA's FY 1993 direct expenditures could well exceed the proposed $1.5 million level of funding for this purpose under the bill. In addition, authorization for grants to non-VA research organizations could adversely affect recruitment and/or retention of VA staff, and present a severe administrative burden to VA. Thus, the proposed special research program contained in sections 3, 5 and 6 is unnecessary and could prove to be counterproductive. Accordingly, we oppose these sections.

Section 4 would require VA to conduct a population study to determine the health-care needs of women veterans. We agree that the proposed study would provide useful information about women veteran's health status and needs. However, because of the great expense that such a study would entail, we recommend that section 4(c) provide that the study be undertaken only if funds are appropriated specifically for this purpose.

As to section 7, we have no objection to the provision requiring reports to Congress concerning the status of research relating to women veterans. We note, however, that subsection (2) also requires the Secretary to transmit to Congress proposals for legislation relating to such research. We believe that this provision as drafted would infringe upon the President's discretion under Article II, Section 3 of the Constitution to recommend for legislative considerations "such Measures as he shall judge necessary and expedient."

We include the following cost estimate for enacting S. 2028.

[In millions of dollars]

Fiscal years:	*Amounts*
1992	13.350
1993	15.353
1994	17.656
1995	20.304
1996	23.351

The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on S. 2028 to the Congress.

Sincerely yours,

EDWARD J. DERWINSKI.

CHANGES IN EXISTING LAW MADE BY S. 2973 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

1710. Eligibility for hospital, nursing home, and domiciliary care.
1711. Care during examinations and in emergencies.
1712. Eligibility for outpatient services.
1712A. Eligibility for readjustment counseling and related mental health services.
1712B. Counseling for former prisoners of war.
1713. Medical care for survivors and dependents of certain veterans.
1714. Fitting and training in use of prosthetic appliances; seeing-eye dogs.
1715. Tobacco for hospitalized veterans.
1716. Hospital care by other agencies of the United States.
1717. Home health services; invalid lifts and other devices.

1718. Therapeutic and rehabilitative activities.
1719. Repair or replacement of certain prosthetic and other appliances.
1720. Transfers for nursing home care; adult day health care.
1720A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities.
1720B. Respite care.
1720C. Noninstitutional alternatives to nursing home care; pilot program.
1720D. Counseling and treatment of women veterans for sexual trauma.

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Subchapter I—General

§ 1701. Definitions

For the purposes of this chapter—

(1) * * *

* * * * * * *

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 1710 and 1712 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive health-care services as defined in section 1762 of this title, *well-women care services,* and (except under the conditions described in section 1712(a)(5)(A) of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(I) of the service-connected disability of a veteran pursuant to section 1712(a) of this title, and

(II) in the discretion of the Secretary, of the non-service-connected disability of a veteran eligible for treatment under section 1712(a)(5)(B) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 1713(b) of this title); and

(ii) in the case of an individual who was a recipient of services under subclause (i) of this clause at the time of—

(I) the unexpected death of the veteran; or

(II) the death of the veteran while the veteran was participating in a hospice program (or a similar program) conducted by the Secretary,

such counseling services, for a limited period, as the Secretary determines to be reasonable and necessary to assist such individual with the emotional and psychological stress accompanying the veteran's death.

For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 1713(b) of this title shall be eligible for the same medical services as a veteran.

* * * * * * *

(9)(A) The term "well-women care services" means health care services provided to women outside the maternity cycle, including counseling and services relating to the following:

(i) Papanicolaou tests (pap smear).

(ii) Breast examinations and mammography.

(iii) General reproductive health care.

(iv) The management of infertility.

(v) Menopause.

(vi) Physical or psychological conditions arising out of acts of sexual violence.

(B) The term does not include the following services:

(i) Pregnancy care (including prenatal and delivery care), except care relating to a pregnancy that is complicated, or in which the risks of complication are increased, by a service-connected condition.

(ii) Abortion.

* * * * * * *

§ 1703. Contracts for hospital care and medical services in non-Department facilities

(a) When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary, as authorized in section 1710 or 1712 of this title, may contract with non-Department facilities in order to furnish any of the following:

(1) * * *

* * * * * * *

(9) Well-women care services for veterans on an ambulatory or outpatient basis, but only under contracts that expire not later than December 31, 1994.

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Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical treatment

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§ 1720D. Counseling and treatment of women veterans for sexual trauma

(a) A woman veteran who is diagnosed by a Department health professional designed by the Chief Medical Director (following an examination of the veteran by such professional) to be in need of counseling or treatment for sexual trauma resulting from events that occurred during the period of the woman veteran's service on active duty, shall be furnished care and services with respect to such trauma pursuant to sections 1710(a)(1)(A) and 1712(a)(1)(A) of this title, even though such trauma has not been determined to be service-connected.

(b)(1) The Secretary may enter into contracts with appropriate non-Department facilities (as determined by the Secretary) in order to furnish women veterans with the care and services (including any diagnostic services) referred to in subsection (a).

(2) Not later than March 31, 1994, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the use made of the authority provided under paragraph (1) before the date of the report. The report shall (A) describe the extent of the use of that authority and the types of care and services furnished to women veterans under contracts entered into under that authority, and (B) contain such recommendations regarding the extension or modification of that authority as the Secretary considers appropriate.

(3) The Secretary may not enter into contracts under this subsection after September 30, 1994. Any contract entered into under this subsection shall expire not later than 90 days after that date.

(c) For the purposes of this section, the term "sexual trauma" means the immediate and long-term physical or psychological trauma resulting from rape, sexual assault, sexual harassment, or other act of sexual violence.

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

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Subchapter I—Organization

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§ 7303. Functions of Veterans Health Administration: research programs

(a)(1) * * *

(d)(1) To the extent that the Secretary determines that the quantity and nature of information available to Department personnel with respect to issues relating to health care for women veterans is

inadequate to permit such personnel to carry out research relevant to the health-care needs of women veterans, the Secretary shall take actions to ensure that medical research carried out by the Secretary gives consideration to issues relating to the health of the general population of adult women in the United States, with particular emphasis on health conditions that affect large numbers of such women and therefore are likely to be prevalent to a significant degree among women veterans and health conditions for which the risk factors, treatment responses, and other factors determined relevant by the Secretary of women veterans may differ from those of the general population of adult women in the United States.

(2) To the maximum extent practicable, the Secretary shall ensure that the personnel engaged in research pursuant to the research program described under paragraph (1)—

(A) include—

(i) personnel of the Department in facilities of the Department, including personnel of the geriatric research, education, and clinical centers designated pursuant to section 7314 of title 38, United States Code; and

(ii) personnel of the National Center for Post-Traumatic Stress Disorder established pursuant to section 110(c) of the Veterans Health Care Act of 1984 (Public Law 98-528; 98 Stat. 2692); and

(B) are informed of the existence and progress of other research relating to women veterans conducted by or under the jurisdiction of the Secretary.

* * * * * * *

APPENDIX

Table 1.—Response to Committee Questionnaire.

	Questionnaires sent	Questionnaires returned	Percent returned
Medical centers	161	131	81
Vet centers	195	177	91
Outpatient clinics	6	4	67
Domiciliaries	1	0	0
Total	363	312	86

Table 2.—Percent of respondents that believe there is a substantial need for treatment or counseling services for women veterans who are victims of sexual trauma.

	Percentage
Medical centers	60
Vet centers	87
Outpatient clinics	100
Total	76

Table 3.—Reasons why respondents believe there is a substantial need for treatment and counseling services for women veterans who are victims of sexual trauma.

[Amounts in percent]

	Medical centers	Vet centers	Outpatient clinics	Total
You are aware, either through reports of research or other means, that sexual trauma is/was a substantial problem in the military	76	82	75	79
Women veterans have discussed personal military experiences when receiving other services	72	92	75	83
Women veterans have presented themselves at your facility requesting such services	59	43	75	50
Other	15	25	0	21

Table 4.—The number of women veterans in medical centers treated for the aftereffects of sexual trauma.

Women veterans treated	Fiscal years		
	1990	1991	1992 to date
None	14	13	16
1 to 25	18	25	31

Women veterans treated	Fiscal years		
	1990	1991	1992 to date
Medical centers responding	32	38	47

Table 5.—The number of women veterans in vet centers treated for the aftereffects of sexual trauma.

Women veterans treated	Fiscal year		
	1990	1991	1992 to date
None	58	61	66
1 to 10	58	69	74
11 to 20	0	0	2
Vet centers responding	116	130	142

Table 6.—Respondents with health-care personnel qualified to counsel sexually-traumatized women veterans.

	Percentage
Medical center	92
Vet center	77
Outpatient clinic	100
Total	84

Table 7.— Respondents who have specific types of health-care personnel on staff to counsel and treat women veterans who have been victims of sexual trauma.

[Amounts in percent]

	Medical center	Vet center	Outpatient clinic	Total
Psychologist	44	10	50	25
Psychiatrist	34	1	50	15
Registered nurse	12	5	0	8
Master degree social work	27	21	50	24
Clinical social worker	6	6	0	6
Readjustment counselor	10	17	50	14
Crisis counselor	1	3	0	2
Training in sex abuse counseling	37	38	0	37
Female counselor	1	8	0	5
Other	21	16	0	18

Table 8.—Average numbers of male and female counselors in each facility.

	Medical centers	Vet centers	Outpatient clinics	Total
Males	6.5	1.7	3.3	3.8
Females	5.44	0.81	4.67	3.64

Table 9.—Respondents who have implemented or are planning outreach programs.

[Amounts in percent]

	Medical centers	Vet centers	Outpatient clinics	Total
Implemented	9	21	0	16
Planned	15	40	0	29

Table 10.—Methods for furnishing counseling services to sexually-traumatized women.

[Amounts in percent]

	Medical center	Vet center	Outpatient clinic	Total
VA furnishes direct counseling	40	16	25	26
Fee-for-service (contract with community agencies)	1	2	0	1
Choice of option depending upon case	58	80	75	71

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